			_ rut	partment of Health and Menta ertificate of Death	al Hygiene 2001	09001
	Dhysici	20	Decedent's Name (First, Middle, Last)	2. Da Mo	te of Death onth Day Yeer	3. Time of Death
	Physici /Medio			nway 3	18 2004	11:35 p. <sup>™</sup>
	Examir	er	4a. Fecility Name (If not institution, give street and number) 624 N. Augusta Avenue	4b. City, Town, or Location of Death	4c. County of Dea	ath
		ш	624 N. Augusta Avenue  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Balto  If Under 1 Year   If Under 24 Hrs.   8 Dai		rthniana (State or Foreign
į.	Funeral Director		214-18-9640  Usuel Residence of Decedent	Months Days Hours Min. (Mo	te of Birth 9. Bi onth, Day, Year) 9. Bi C	rthplace (State or Foreign country)  Md
	yland		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mar Mar	ctor	Md N/A Balti	more		1 XYes 2 ☐ No
	ath with the Marylar 23a or 28e-f ahow	Jire	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
	23a	a	624 N. Augusta Avenue	21229	USA	
36	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28e-f ahow ent, it in Medical Examinator motified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  13. Yes 2 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican,</li> <li>Yes 2 No Specify:</li> </ol>	etc.) 14. Race - Am Black, Wh	
5-0036	2 hou	ted	15. Decedent's Education 16a. De	cedent's Usual Occupation	16b. Kind of Business	s/Industry
2 2 2	nin 7	Completed	(Specify only highest grade completed) (G.	ve kind of work done during most of working b. DO NOT use retired)	Baltimore	Construction
2121	giene giene grtha	Com		rick layer	Institut	te
Maryland	e a la b €	To Be (	17. Father's Name (First, Middle, Last) William Conway	18. Mother's Name (First, Lillian La	Middle, Maiden Sumame) ine	
	s 1 and 2 should t Health and Mer item 27 is marke other traumatic			uling Address (Street and Number or Rural Route N. Denison Stteet Ba		Zip Code)
altimore,	of Hear		l comotons o	position (Name of Pate rematory or other place)	20c. Location - City o	r Town, State
Ĕ	Pages nent of ent: If it ury or o		LAburiai 2 Licremation 3 Linemoval from State	ville Veteran 3/23/200	4 Crownsvil	le, Md
ä	permit. Pages 1 Department of H Importent: If its any injury or ot		21. Signature of Fundal Shrvice Licensee	22. Name and Address of Facility March	.7.	
m	202 = 3		Junette 15 Junes		h Avenue Balt	o, Md 21215
	Physician		23a. Part 1. Enfer Me disease, or complications that dused the death. Do not shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition	enter the mode of dying, such as cardiae-or respi nextate Cancer	ratory arrest,	Approximate Interval Between Onset and Death
1	/Medical Examiner		Due to (or as a consequence of):		1 /	1 /
		5	Sequentially list conditions, if any, leading to immediate  b. CWonic Obstruction  Due to (or as a consequence of):	De Pulmonary Disease	exacerba tran	Weeks
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury			
ĵ.	execting and and ital-tra	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
9/60	ate be executed thysician and the burial-transit	Icai	d			
õ	rtifica ng ph as th		IF FEMALE:			
O. Box	at the death certificate be executed by the attending physician and tached for use as the buriat-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death	B⊟Ectopic pregnancy 5⊡ Other (specify)	23d. Date of de Month	alivery Day Year
J.	The law requires that the te has been signed by th bage 2 should be detache	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	e. Did tobacco use contribute	to the cause of death2
ecords,	w requires that been signed to should be deta	ed ba	Jeripheral Vascular Lisease,	typer tension	1 Yes 2 No 3 P	robably 4 Monknown
ပ္ပ	s bee	piet	Anemia of directe directe	24	a. Was an 24b. Were a	utopsy findings available
	sician: The law certificate has b irector, page 2 s	Completed			autopsy prior to death?  Yes 2 1 Ye	
Vital K	sician: certifica irector, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec		
0	Physic this ce al dire	To	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		Residence 6 Other (Spe	ecify)
Ĕ	ttending P death. stor: After t the funera	lon:	27. Manner Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	/ Work?	escribe how injury occurred	
120	Attendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be determined by the suicide of the determined and the suicide of the suicide o	M 1 Yes 2 No	ention (Street and Number of F	Dural Paula Mumbas
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Certification:	4 Homicide determined building, etc. (Specify)	Cit	cation (Street and Number or F y or Town, State)	
	ne Hoss n 24 ho ne Funs bletely fi	Medical	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, de (Check only one)  1. Certifying Physician: To the best of my knowledge, de (Check only one)  2. Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	e to the cause(s) and manner a te time, date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	X	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	th, Day, Year)
)	X		per & dece physicia	n D52544	March 22	, 2004
	10,		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	11- 1017 3	1220
	,	A	Benjamin 5 Lee, m.D., 100 GEID 31. Date Jiled (Month, Day, Year) 32. Registrar's Signature	e Rd #204, Catous	ville, MO 2	1440
A.	Sta Registr		MAR 2 2 ZGG4	book		

DHMH 17 Rev 1/2001

ORIGINAL

				1 - State of Maryland / Department of Health and 1  Certificate of Death		Reg. No. 2 U	04	090	002
		Physici		1. Decedent's Name (First, Middle, Last)  Abraham Capers	2. Date of De Month	eath Day	Year 2004	3. Time of 3, 00	Death A M
	-	/Medi Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	h	4c. Count	y of Death		
				Sinai Hospital of Baltinione Baltimore a	79				
		Funeral Director		5. Social Security Number 212-78-4907  6. Sex 2 F  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, D	irth ay, <i>Year)</i> -1959	9. Birthi Coul	olace (State ontry)  Md	r Foreign
S		P .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location					9 11 - 0 -
FR		s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene flem 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event. The Medical Example interests to tilled at	tor	Md N/A 10c. City, Town or Location Balto				10d. Inside Ci 1 <b>∑</b> Yes	*
547		or 28a	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Cou	ntry?	
0		ath w	ra	2805 Ulman Avenue 21215		US.			
Z	(0	r Items	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	ipecify Yes or N to Rican, etc.)	0- 14. Ra Bla	ce - Ameri ck, White,	can Indian, etc.	
444	003	72 hours after "natural", or Ite	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify:		Speci		ack 	
ABRAHAM	21215-0036	in 72 t	Completed	15. Decedent's Education (Specify only highest grade completed)  [Second Second	rking	16b. Kind of E	Business/In	dustry	
A	212	e filed within all Hygiene. I other than "r	Com	Elementary/Secondary (0-12) College (1-4or 5+)  N/A  N/A	N/A				N/A
63		be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (Last)			71e)		·
	Maryland	2 should be and Mental I is marked or raumatic eve	To		e Mae		State 7in	Codel	
3		s 1 and 2 s f Health an item 27 Is other trau		19a. Informant's Name/Relationship (Type, Print)  Ralph Friendlich - Director  19b. Mailing Address (Street and Number or Fu Sul				(0000)	
3	Baltimore,	ges 1 a t of Hea If item or othe	)	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location	- City or To	own, State	
2	ţi	t. Pag trment rtant:		'4 □Donation 5 □Other (Specify) Mt Carmel Cemetery 3-22		Balto,			
Portieut Known	Bal	permit. Pages Department of H Important: If ite any Injury or of			March F Wabas	'/H West h Avenue			21215
43		1 3 6 7	Г	23a. Part1. Enter the diseas, for complications that cars of the death. Do not enter the mode of dying, such as cardiac shock, or heart failury. Let only one cause on a conline.				Approximat Interval Bet	te ween
	•	Physician	ı	Immediate Cause (Final disease or condition resulting in death)  a. Acute liver fullier				Onset and I	Death
		/Medical Examiner	ı	Due to (or as a consequence of):					13
		D ==	ner	Sequentially ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	- 5	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):					
	8760,	cate be executed by sician and the burial-transit		d					
	68	entifica ing ph	Medi	IF FEMALE:					
	Box 6	eath cer attendin for use	clan/	23b. Was decedent pregnant in the past 12 months?			ate of deliver	-	Year
	0.	that the deathed by the atte	Physiclan/Medlcal	1 Yes 2 No 9 Unknown 9 Unknown					
	of Vital Records, P.O.	res tha signed I be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use con	tribute to t	1	death?
	Sorc	v requires been sign should be	eted	- Deari - Start - Star	24a. Wa			opsy findings	
	Re	The lay	Completed		auto	opsy formed? 2 X No	prior to co death? 1 \(\sum \) Yes	mpletion of c	ause of
	'ital	srtifica ctor, p	BeC	25. Was case referred to medical examiner?			100	2,110	
	of V	hysic this ce al dire	2	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H		sidence 6 🗆 Ot		<i>'y)</i>	
by		tending Physician: The leath. tor: After this certificate his the funeral director, page	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury Work? 1 Natural 5 Pending (Month, Day Year) 1 Natural 1 Yes 2 No	28d. Describe	how injury occu	rred		
	Division	r Atten er dea rector by the	tiflca	2 Nacuent 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)		(Street and Num	ber or Run	al Route Num	iber,
	Ö	oital or urs aft eral Di	Cer						
		To the Hospital or Attending Physician: The law requires that the death certificate i within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the t	edical Certification:	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the basis of examination and occurred at the basis of examination at the basis of examination and occurred	urred at the time	, date and place.	and due t	tated. o the cause(s	<b>à</b> )
		To th Within To th comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date signe	ed (Month,	Day, Year)	
		\		▶ JBudaushoute RES - Occ	>	Karch	18,	2004	)
				29b. Signature and title of certifier  J. B. W. Claus W. Lie  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  GITANA BRADAUSKA (TE MD SINGLE HOSPIFOL OF  31. Date filed (Month, Day, Year)  MAR 2 2 2004	L Box	tim or	,		
			ate	31. Date filed (Month, Day, Year) 82. Registrar's Signature					
		Regist	rar	MAR 2 2 ZUU4 ASSA 200 200 ASSA					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 4:55 pm/ March 19, 2004 Louise Corcoran Marie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Center for Hospice | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 4/23/1937 Birthplace (State or Foreign Country) If Under 1 Year Months Days Age (In yrs. last birthday) **Funeral** Months 1□ M **X**□ F Maryland Director 215-34-8621 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examinal must be tradified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Essex the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number S. A. 21221 4 Woody Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify. þ 3 ☐ Widowed 4 ☒ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) filed within Hygiene. permit. Pages 1 and 2 should be filled win Department of Health and Mental Hyglens Importent: If item 27 is marked other that any injury or other traumatic event. Item 2006. Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Janney Catherine Mary Linsey Hurt Peter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 4 Woody Road Essex, Maryland 21221 <u>Patricia Carole Myrtle</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3/23 2004 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Brooklyn Park, MD Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es 21. Signature of Funeral Service Licenses Essex, Maryland 21221 50. charle . Jag Lian 23a. Part1. Enter the disease or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) jears Breast metrotatic **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, sician use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Ö 2 should be detached 9☐ Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Artery di Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 1 ☐ Yes 2 ☐ No 2/1 No 1 ☐ Yes Vital Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 5 o 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Medical Certification: After the Hospitel or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the th Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Surcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide within 24 hours a 1 S. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier march 20, 2004 125205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G Bonc 6281 N. Charles St. Balto and 2150 Jus W. A. Riley 32. Regi**str**ar's Signature 31. Date filed (Month, Day, Year)

Registrar

MAR 2 2 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200109004 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** sle march 15,200' /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore General Birthplace (State or Foreign Country) If Under 1 Year | If Unde 5. Social Security Number last birthday) **Funeral** Months Days Hours 1**X**M 2□ F 9258 Director Od. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, Ite M. circal Examiner must be nutified at 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2/2/ Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 XN0 1 Never Married 2 Married 1 ☐ Yes 2 →No Daven Dirt John Baltimore, Maryland 21215-0036 Specify: Specify: ac 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ongary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden 17 Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number Relationship (Type, I St. Barto.MD JOHN C 20b. Place of Disposition (Name of 20c. Location - City or 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 104 ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee KRd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ·Arterioscleratio CardioVascular Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Donknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 0 No 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 2 PER/Outpatient 3 DOA Certification: To 1 Inpatient this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? completely filled in by the funeral 27. Manner of Death After 1 Natural 5 | Pending 1 Yes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) General Maryland el ni 32. Registrar's Signature State Registrar

	1	For State Registrar	e of Maryland / Dep Ce	partment of H e <i>rtificate of L</i>		ental Hygi Re	g. No. 2004	0900
Physicia		. Decedent's Name (First, Middle, Last)	urence Prenti	iss Diggs,		2. Date of Death Month 3	Day Year 21 2004	3. Time of Death
/Medica Examine	er '	a. Facility Name (If not institution, give street an Gilchrist	d number)	4b. City, Town, or Towson	Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 213-26-8572  Usual Residence of Decedent	7. Age (In yrs. last birthda 73	Months Days	Hours Min.	8. Date of Birth (Month, Day, 7-2-19		pplace (State or Fore untry)  Md
Maryland -f show		10a. State 10b. County Md N/A	10c. City, Town or Balto	Location				10d. Inside City Lim 1 X Yes 2 □
with the a or 28e be noti	Director	10e. Street and Number 1233 Stamford Road		10f. Zip Code 2120	<b>17</b>	10	Og. Citizen of What Cou	untry?
paritimities, Wally failed A. I. L. 10.000. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other treumatic event, the Madical Examiner must be natified at once.	by Funeral	11. Marital Status 12. Was 1 ☐ Never Married 2 ☒ Married 1 ☒ 1 ☒ [Ye	Decedent Ever in U.S. 13 ad Forces? Yes 2 \( \subseteq \) No s, Give or Dates:	3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1	, etc.
in and yearing A. I.	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Collett grade	ated) 16a. De (Gi (Gi (Jife N/A	cedent's Usual Occupa ive kind of work done of e. DO NOT use retired Transit Di	during most of workir l)	ng 1	M.T. A	ndustry
d be filed ental Hygi ced other c event,	To Be C	17. Father's Name (First, Middle, Last)  George Diggs	21/22		18. Mother's Name	(First, Middle, M a Deaver		
id 2 should the and Me 27 is mark treumati	Ξ.	19a. Informant's Name/Relationship (Type, Prin Hazel Diggs - Wife	·	ailing Address (Street a	and Number or Rura	l Route Number,	City or Town, State, Z	lip Code)
Callimore, mit. Pages 1 an partment of Heal portent: If item 2 y injury or other 168.	i	20a. Method of Disposition  ¶\$\text{Normal}\text{Burial} 2 □ Cremation 3 □ Removal  4 □ Donation 5 □ Other (Specify)	from State cemetery, o	sposition (Name of crematory or other places on Forest	3-25-	-2004	Owings Mil	
permit Depart Import any in		21. Signature of Funeral Service Licensee	S. Jones	22. Name and Addre	4300 V	arch F/H Wabash A	venue Bal	to, Md 2
Pnysician /Medical Examiner	<b>.</b>		ue to (or as a consequence of):	cytom		in toppidatory and		Approximate Interval Between Onset and Deat
Hecolds, F.O. Box 06/00,  The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	ue to (or as a consequence of):					
that the death certificate by the attending ped by the attending pedetached for use as	Physician/Me	in the past 12 months?		3 Ectopic pregnancy 5 Other (specify)	1		23d. Date of del Month	ivery Day Year
uires that the signed by	by	Part II. Other significant conditions contributing	g to death but not resulting in th	e underlying cause giv	ren in Part I.	23e. Did tob	pacco use contribute to es 2 No 3 □ Pr	the cause of deat obably 4 \(\sum \subseteq Unki
VITAI MECOTO: ician: The law require certilicate has been sir	Completed					24a. Was a autops perform	v prior to	itopsy findings ava- completion of cause
on of Vital  Jing Physician: h. After this certifications of the contraction of the contr	Certification: To Be C	1 Natural 5 ☐ Pending investigation	Date of Injury (Month, Day Year)  28b. Tim Inju	ne of 28c. Injury World 1	y at rk? Yes 2 □ No	n <i>(Check only on</i> me 5 ☐ Reside 28d. Describe ho	e) ance 6 COther (Spe ow injury occurred	
= 5 ± ± = =		4 Homicide determined 286	Place of Injury - At home, larm building, etc. (Specify)			City or Towr		
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	(Check only 2 Medical Examiner: Or	To the best of my knowledge, on the basis of examination and/odmanner stated.	or investigation, in my	opinion, death occurr	red at the time, d	ate and place, and due	to the cause(s)
12	Σ	29b. Signature and title of certifier  How home	Paley . mx	29c. Licens	5205		MAVe43	11. 2000
<u>D</u>		30. Name and address of person who complete	BMC 6701	(pe. Print) Cha	ileo St.	Bali	to. Md 21	295
Sta Registi		31. Date liled (Month, Day, Year) MAR 2 2 2004	32 Registrar's Signature	book				

1	For State Registrar	State of Maryland		ment of He icate of D		lental Hygier	ne 200L	
Physician /Medical Examiner 4	1. Decedent's Name (First, Middle, Last)  Edward  18. Facility Name (If not institution, give s  1300 E. Lanvale	Street Apt. 8	300 <sup>46</sup>	Balti	Location of Death  MOCE  If Under 24 Hrs.	3 17	4c. County of Deet	
Director	5. Social Security Number 6. Sex 231–20–4898	7. Age (In yrs. li		Under 1 Year onths Days	Hours Min.	8. Date of Birth (Month, Day, Ye 11-5-30	ar) 9. Bin	hplace (State or Foreign untry) Y
fied at	Md. NA		, Town or Locati Baltimor					10d. Inside City Limits  Y Yes 2 □ No
ritems 23a or 28e-fsi	10e. Street and Number 1300 E. Lanvale S	street Apt.		10f. Zip Code 21202		10g.	Citizen of What Co USA	untry?
ar, or items 2	11. Marital Status  1 □ Never Married 2√2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If ♣es, Give Year or Dates:	If Ye	Decedent of His es, specify Cubar Yes 22 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B	
ygiene. her than "natura t, the Medical E Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation a <i>completed)</i> College (1-4or 5+)	(Give kind life. DO	NOT use retired)	uring most of work	ing	. Kind of Business	
atic event, I	9th grade 17. Father's Name (First, Middle, Last) William	Beld		f-Employ	18. Mother's Name Rose	e (First, Middle, Maid	Fruck Dri den Sumame) Gibb	
n 27 is m	19a. Informant's Name/Relationship (Ty Alberta Davis 20a. Method of Disposition 1↓ Burial 2 □ Cremation 3 □ F	Wife 20b. P		E. Lanva	le St. A			, Md. 21202
Importent: eny injury once.	4 Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	Lo Lo		rk ame and Addres rch F.H	•	Baltimo	altimore, re, Md. North Ave	21202
ysician Medical aminer	23a. Part1. Enter the disease, or amplishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	ANCER	he mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death I YEAR
ysician and se burial-trans cai Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequence.  Due to for as a consequence.					=======================================	
ed by the attending ph detached for use as th detached for wee as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3□Ec	topic pregnancy ther (specify)			23d. Date of de Month	livery Day Year
Pe d	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the unde	rlying cause give	en in Part I.	23e. Did tobac 1 ☐ Yes		o the cause of death? robably 4 💆 Unknown
oage 2						24a. Was an autopsy performed 1 □ Yes 2	prior to death?	utopsy findings available completion of cause of 2 2 No
director, p	25. Was case referred to medical examiner?	Hospital:	FB/Outestant	Othe	*	th (Check only one) ome 5 🖫 Residence	o 6 □Other (See	orific)
fter this neral d	1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	4   Nursing m	28d. Describe how		<i>⊶,,</i> ,
To the Funeral Director: After I completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street y)	, factory, office		28f. Location (Stree City or Town, S		ural Route Number,
mpletely fille		sician: To the best of my kno iner: On the basis of examina and manner stated.		stigation, in my op	oinion, death occur	red at the time, date	and place, and du	e to the cause(s)
Tot	29b. Signature and title of certifier			29c. License			Date signed (Moni	
X,	30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type, Pri		57802	M	ARCH 18	2004
State	WELLS MESSERSMIT.  31. Date filed (Month, Day, Year)  MAD 2 2 2000A	74, m 0 Johns Holl 32. Registrar's Signa	KDVS CRE	186 1650	orleans	STREET, BA	LTIMME, A	MARYLAND ZIZ

			For State Registrar		State of				t of H	ealth a	and M	lental Hy	giene Reg. No	200	ŧ 0	900
770	Physici /Medio Examin	cal	Decedent's Name (First, Magnetic Josephine     Aa. Facility Name (If not institute)	tution, give	Elder street and nun		261	4b. City,	Town, or	Location of	of Death	2. Date of De Month MARCI	4 /9	County of Dea	1 00	me of Death  M
	uneral irector		5. Social Security Number 203–20–9179 Usual Residence of Deceder		/ / 4	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 12/28/	a <i>y, Year)</i>	Co	hplace (5	State or Foreign Vania
G Z IZ IS-UUSO filed within 72 hours after death with the Maryland Hygiene.	Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination Instituted at once.	ral Director	Maryland Son 10e. Street and Number 4048 Back She	<sup>unty</sup> erset	wn Road	Mar	ity, Town or Lo	ation 10f. Zip 218	Code				U.	izen of What Co	1 Country?	ide City Limits ]Yes 211 No
Z I Z I D-UUSO Id within 72 hours after de giene.	atural', or Item Isal Ezamenacı	ted by Funeral		rced edent's Edu		ces? 2 <b>∏X</b> No e	16a. Dece	1 🔲 Yes	No No al Occupa	Specify:		ecrfy Yes or No Rican, etc.)		14. Race - Ame Black, Whit Specify: Wind of Business	e, etc. hite	an,
be filed within 7 tal Hygiene.	d other than "r event, the Nex	Be Completed	(Specify only in Elementary/Secondary (0-8)  17. Father's Name (First, Min	12)	College (1	-4or 5+)	Homen	kind of wo DO NOT u laker	se retired	)		(First, Middle		n Home Sumame)		
E, Maryland  1 and 2 should be file  4ealth and Mental Hy	am 27 is marke ther traumatic	To	John Perow 19a. Informant's Name/Rela Michael P. El 20a. Method of Disposition		(Son)	201-	4112	. Beec	hwoo	and Numbe	or or Rura		, Ma.	r Town, State, I	21222	
<b>Galtimore,</b> permit. Pages 1 ar Department of Hea	Important: If ite any injury or ot once.		20a. Method of Disposition  Burial 2 Crema  4 Donation 5 Oth  21. Signature of Funeral Se	er (Specify)	see	Gā	B	of Fa <sup>2. Name ar</sup> Bruzdz	ith od Addres zinsk	Cem.	3/2 200 peral	22 34 Home	Bal PA	timore,	Mary	land
Phy /M	sician edical miner		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or comp List only o	lications that can be cause on ea		th. Do not en	ter the mòc	le of dying	g, such as	cardiac c	or respiratory a	irrest.	X, Mary	Appro Interva Onset	21221 eximate al Between and Death
fe be executed	ysician and e burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	c	or as a consec										
MISIOI OF VILAT RECOIDS, F.O. BOX 00 Attending Physician: The law requires that the death certifical reasth.	ed by the attending phi detached for use as th	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	it [		inth 2 ☐ Feta ant at time of a	al death 3	⊒Ectopic pi ⊒ Other (sp				,		23d. Date of del Month	ivery Day	Year
w requires that	been sign should be	Completed by Pt	Part II. Other significant co.	ditions co	ntributing to de	ath but not re	sulting in the u	inderlying c	ause give	en in Part I.			Yes 2	se contribute to	obably	4 □Unknown
VII.a. ITA	certificate has rector, page 2	Be	25. Was case referred to me examiner?	-	Hospital:						of Death	auto perfe 1 ☐ Yes	2/X/No	death?	completion 2□ No	dings available n of cause of
DIVISION OF VITAL RECORDS, To Attending Physician: The taw requires that repeated that the taw requires to the result.	After this funeral dis	Certification; To	2 Accident in 3 Suicide 6 □ C	ending vestigation ould not be	28a. Date of	of Injury h, Day Year)	28b. Time of Injury	of A	8c. Injury Work	at	No	28d. Describe	how injur	6 Other (Specy occurred)  d Number or Ru		Mumher
To the Hospital or A within 24 hours after	To the Funeral Director: completely filled in by the	edical Certif	29a. Certifier	itermined tifying Phy lical Exami	buildir	best of my kn	ify) owledge, deat	h occurred	at the tim	e, date and	d place, a	City or To	wn, State	and manner as	stated.	
To the	To the	Med	29b. Signature and title of co	0. 7.	1		m 22a) (Time-		D3 (		-6		3	e signed (Mont		
*	Sta Registr		30. Name and address of periods of the Power State of the	P.	32. R	e of death (Ite	ature	00 E	- Ch	MAN	11	31	5,	4 213 bu	M 1.	<i>no</i>

		1 - For State Registrar	State of Marylan	d / Depa	artment of H	lealth and Death	Mental Hy	giene Rag. No.	2004	09008
Plantis		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath . , Day	Year	3. Time of Death
Physici /Medic		Maxine	Pearl		Geize		MAR	CH 1	9,2004	1100 p.M;
Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	Location of Deat	h	4c.	County of Death	,
		FRANKlin SQUARE	HOSPITAL		Kose C	IALL		1	ALlim	DPC.
Funeral		5. Social Security Number 6. Sex		last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Da	ay, Year)	Cou	
Director		219-22-9485 Usual Residence of Decedent	<sup>M 2</sup> X F 79	115.			Jan. 2	6 19	25 W. V	irginia
and *		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
ith the Marylan or 28a-f show	ō	N1 P-1	-	1 11						1 ☐ Yes 2 ☐ No
the 288-	Director	Maryland Baltimor	e <u> </u>	<u>undalk</u>	10f. Zip Code			10g. Citi	izen of What Cou	ntry?
with se or		7111 Eastern Ave	niie		21224				U.S.A.	
leath	by Funeral		2. Was Decedent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No	o-	14. Race - Ameri	
fler c	E	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No				to Rican, etc.)		Black, White,	etc.
al', o		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2½ ☐ No	Specify:			Specify: Whi	te
filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene then "natural", or Items 23s or 28s-f show ent, the Medical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	nation during most of wo	rkina	16b. Ki	ind of Business/In	ndustry
thin 6	nple	Elementary/Secondary (0-12)	College (1-4or 5+)			d)	•			
ed wi	Son	11	NA	Homes	Maker				wn Home	<del></del>
d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden	Sumame)	
should be and Mental marked o	ို	Alvin	S	Hauger		Lela	M	•		aylor
2 sh and and is m		19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (Street	and Number or R	urai Route Numb	er, City o	r Town, State, Zij	o Code)
1 and 1 Health Health 27 other tr		Stephanie Clark	( Daughter )		l Eastern	n Avenue				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Maralal Hygiens. Thimportant: If item 23 a or 28s-f show any injury or other traumatic event, It a Medical Examinar must be notified at once.		20a. Method of Disposition  1 XBurial 2 Cremation 3 R	1 0	emetery, crei	sition (Name of matory or other plac	ce) Man	cch 23,	20c. Lo	ocation - City or To	own, State
Pag ment ant: ury		`4 Donation 5 ☐ Other (Specify)		Sacred	Heart of	F Mary 2	2004	Dune	dalk, Ma	ryland
permit. Departn Imports any inju		21. Signature of Funeral Service License	ne _ // _	22	Name and Addre W. Dabrov	ss of Facility JSki-Cho	inacki F	unera	al Homes	P.A.
20529		Mark a, ho	mecke	1	005 Dunda	alk Ave.	Baltimo	re, l		21224
		23a. Part V. Enter the disease, or complished shock, or heart failure. List only on	cations that caused the death e caus—on each line.	n. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Pulmoni	aru	Fibro	1515				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
Examiner	L	Sequentially list conditions,								
sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	uence of):					-	
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Саш	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
sician buria	E		500 to (51 43 4 5511354	donod or).						
physi s the t	dical	d								
ding passe as	Physiclan/Med	IF FEMALE:	3c. If yes, outcome of pregna	nov.					2010	
ath c	an	23b. Was decedent pregnant in the past 12 mainths?	1☐Live birth 2☐Feta	I death 3	Ectopic pregnancy	4		1	23d. Date of deliv Month	ery Day Year
the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at time of d 9□ Unknown	eath 5L	Other (specify) _					
v requires that the death certific been signed by the attending p should be detached for use as		Part II. Other significant conditions con	tributing to death but not res	ultina in the u	nderiving cause giv	ven in Part I.	23e. Did	tobacco u	ise coptribute to t	he cause of death?
requires l	1 by		<b>3</b>	•	, ,		10	Yes 2	No 3 □ Proi	bably 4 Unknown
w requir been si should	Completed									E. C Inhits
e law has l	du						24a. Was		prior to co	opsy findings available ompletion of cause of
ding Physician: The lav h. After this certificate has funeral director, page 2	ပိ						1 ☐ Yes	2 No		2□ No
Physician: r this certifican ral director, I	Be	25. Was case referred to medical examiner?	ospital:		Ott	or.	ath (Check only			-
this aldi	2	1 Yes 2 No	Tunpatient 2	ER/Outpatier 28b. Time o	IT 3L DUA	4   Nursing I	dome 5 Res		6 □Other (Special	fy)
ding P. After funera	lo	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	Wor	rk? Yes 2 □ No	200. Describe	riow irijar	y occurred	
ttend death ttor:	Certification;	2 Accident investigation 3 Suicide 6 Could not be	On Diago of Injury . At he	oma farm st		163 2 110	28f Location	Street an	d Number or Rur	al Route Number
or A lifter Direction by	Ħ	4 Homicide	28e. Place of Injury - At he building, etc. (Specif	y) y)	eet, ractory, office		City or To			ar riodia ridindar,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune fune.		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wladae dast	h accurred at the time	me date and plan	and due to the	causo/s)	and manner as a	tated
Hos 24 ho Fun	edical		ner: On the best of my kno ner: On the basis of examina and manner stated.							
o the thin i	Med	29b. Signatue and it le of carlifler	and mainter stated.		29c. Licens	se number		29d. Dat	e signed (Month,	Day, Year)
F 3 F 8		1-+	001						. 14	20011
n	1	masternes	Salar	- 02-1 CT		0453			2CH 19	2004
10		30. N m nd address of person who	mpleted cause of death (Item	n 23a) (Type,	Print)	ARE DV	10 -Rn	Hinn	NO MA	in I and
		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	ann Ogu	FICE IN	IVE UM	FILAN	me In	1 11111
St: Renist		MAD 2. 2. 2004	Grand and to	9 1	oaks				26	21201

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dey **Physician** 1330 Ida Green FEBRUARY 272004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth c. County of Death Examiner SpECIAlty HOSPITA If Under 24 Hrs. P. D. If Under 1 Year 8. Date of Birth (Month, Day, Yeer) 12-31-18 Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Va. Funeral Days Months 1 ☐ M 2 🖫 F 85 Director 217-01-9275 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits frems 23s or 28s-f show iner must be notflied at Baltimore 1X Yes 2 □ No Md. NA Director 10e Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2423 Arunah Ave. 21216 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: δ Black 3 ♥ Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mail Sorter Post Office 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilson Mildred Wallace John Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 2423 Arunah Ave., Baltimore, Md. Richard Green 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-5-04 Garrison Forest Vet. Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. Wan March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or compilitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Examiner wound Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last deficiency Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the causs of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 Ø Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 ☐ Yes 2/1 No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide

/Medical Examiner physician and the bunal-transit The law requires that the death certificate be executed 68760, attending pt Division of Vital Records, P.O. ate has b After this certificate ompletely filled in by the funeral or Attending efter death. 24 hours within 2

f Health end Menta Item 27 is merked

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

D34974

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) (MARY MENTA, MD, 601 South charles It rect, Baltomore, MD 21230 31. Date filed (Month, Day, Year) State

edical

A Mohter us

29b. Signature and title of certifier

32. Registrar's Signature

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 2001

ngnin

	1 State Registrar		Cei	tificate of De			g. No.	0 5 0 1 0
Physician	1. Decedent's Name (First, Middle, Las	•				2. Date of Death Month	Day Year	3. Time of Death
/Medical	Ann Taylor Gould					March	20, 2004	10:35 A
Examiner	4a. Facility Name (If not institution, give 611 Marwood Road	street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of Oeeth Balt	imore
Funeral Director	215-32-50/3	ex 7. Age (In yrs. 70 70 70 70 70 70 70 70 70 70 70 70 70	last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 21	Year) 9. Birth Con 1933 Ma	place (State or Foreig Intry) Cyland
yland	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
vith the Man t or 28a-f sh be notified Director	MD Baltimor	e Tow	vson					1 ☐ Yes 2 🗖 No
or 26	10e. Street and Number			10f. Zip Code		1	g. Citizen of What Co	untry?
ifter death v in itema 23a char musi Funeral	611 Marwood Road	12. Was Oecedent Ever in U	.S. 13. \	21204 Was Decedent of Hispari Yes, specify Cuban, I	anic Origin? (Spe		JSA 14. Race - Amer	
within 72 hours after death with the Maryland ane. than "natural", or itema 23s or 28s-f show the Madical Examinat must be notified at modified by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Mexican, Puerto I Specify:	Rican, etc.)	Black, White	
"natural	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	lent's Usual Occupatio kind of work done duri OO NOT use retired)	on ing most of working	ng 1	6b. Kind of Business/I	ndustry
be filed within 72 hor tal Hygiene. Ind other than "natural event, the Medical Each Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		tered Nurs	se.		Nursing	
d 2 should be filled within 72 hours all the and Mental Hygiene. It is marked other than "natural", or traumatic event, the Medical Example To Be Completed by F	17. Father's Name (First, Middle, Last)	<u> </u>	1,199.10		3. Mother's Name			
2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	Wesley A. Taylor				lary Virg			
lith ar lith ar 27 ie r trau	19a. Informant's Name/Relationship (Victoria P. Hulic	k / daughter	5636	Governors	Pond Cir	:; ALexa	City or Town, State, Z andria, VA	
Page nent o ant: If ury or	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specify	Hemovarirom State		sition (Name of natory or other place) alley Mem.			oc. Location - City or 1	
permit. Page Department o Important: If eny injury or once.	21. Signature in Ingral Service Licer	luf	Ru	. Name and Address of CK Towson	Funeral		1050 York Towson, M	
Physician /Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Hype Vensure Due to (or as a conseq	athen				1	Approximate Interval Between Onset and Death
tificate be executed up physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conseq  d.						
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burral-transit completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of deline Month	very Day Year
w requires that been signed by should be deta	Part II. Other significant conditions of		sulting in the u	nderlying cause given i	in Part I.		acco use contribute to	the cause of death?
: The law requir cate has been s page 2 should Completed		and the state of t				24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
cien ertiff, actor	25. Was case referred to medical examiner?	Manufali			6. Place of Death	(Check only one	)	
4 a a	1X Yes 2 No 27. Manner of Death 11X Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		ne 5 Resider 8d. Describe hov	ice 6 XOther (Spec v injury occurred	(fy) SCENE
tal or Attending Presents after death. al Director: After ted in by the funeraction by the funeraction:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		ome, farm, str fy)			8f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune Medical Certification		ysician: To the best of my kno niner: On the basis of examina and manner stated.						
within To the comple	29b. Signature and title of certifier		<u></u>	29c. License ni	umber		d. Date signed (Month	
	Jasha ? ?	heerber my	D	0.	C.M.E.	Me	arch 21, 20	004
	30. Name and address of person who	completed cause of death (Item	m 23a) (Type	Print)				
10	Tasha Z arent				et, Bali	imore.	Maryland 2	1201

			For State Registrar		State o	of Maryland		artment of H		ınd Me		ene g. N2 0	04	090	
	Physici	an	1. Decedent's Name (First, A		,	-/-				2	. Date of Death Month	Day	Year	3. Time of	Death
	/Medic	al	Bess			-1+2					March	19	2004		M
7	Examin	er	4a. Facility Name (If not insti Anne Arunde					4b. City, Town, or Annapo		f Death			ty of Death		
	Funeral		5. Social Security Number	6. Se	×	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 2		. Date of Birth (Month, Day,		9. Birth	del place (State or ntry)	r Foreign
	Director		215-32-9204		⊒M 2 <b>X</b> 2F	95	Yrs.	Months Days	Hours	Min. M	ay 26,	1908	Mary		
	and w	1	Usual Residence of Deceder 10a. State 10b. Co			10c. City	, Town or Lo	cation						10d. Inside Cit	y Limits
	Many I she	ģ	MD Ann	e Aru	nde1	A	nnapo:	lis						1 🔀 Yes	2 🗌 No
	or 28s	Director	10e. Street and Number					10f. Zip Code			10	g. Citizen of	What Cou	ntry?	
	ath wi		15 Steele A	venue				2140				USA			
10	ter de Items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐	Married	12. Was Dec Armed Fo 1 ☐ Yes			Was Decedent of H If Yes, specify Cuba	ispanic Orig in, Mexican,	jin? (Spect , Puerto Ri	ty Yes or No- can, etc.)		ace - Ameri ack, White,		
036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jiest Examiner must be notified at	þ	3 X Widowed 4 □ Divo	1	If Yes, Gr Year or D	ve		1□Yes 2XX No	Specify:			Spec	ify: W	hite	
5-0	J within 72 hours after death with the Marylan jiene. r than "naturat", or Items 23a or 28a-f show the Medical Examinat must be notified at	Completed	15. Dec (Specify only h	dent's Edi	ucation de completed)		(Give	dent's Usual Occup kind of work done	during most	of working	1	6b. Kind of	Business/In	ndustry	
121	within ene. than "	ldmo	Elementary/Secondary (0-	12)	College (	1-4or 5+)		00 NOT use retired -employed	1)			Retail	1		
d 2	Hyg Hyg ent,	Be Co	17. Father's Name (First, Mic	ldle, Last)			DCTT-	-ешртоуец	18. Mother	r's Name (i	First, Middle, M				
/lar	0 to 0	To B	Samuel A. G	ceenf	ield				Juli	ia Bro	own				
Maryland 21215-0036	and aum		19a. Informant's Name/Rela Herman Grit:					ng Address (Street							14
	1 an Heal em 2 ther		20a. Method of Disposition	(50)		20b. PI		1 Pretor: esition (Name of matory or other place		ive,		Sprin. Oc. Location			
ē	50		1XXBurial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			State		natory or other plac Israel Ce		3/21/2	2004	Annapo	nlie	MD	
Baltimore,	permit. Page Depertment of Important: If any injury or or a.	1	21. Signature of Funeral Se			1 202		2. Name and Addres	ss of Facility	Y			,110,	110	
	22529		13-7	Y.				Hardesty 12 Ridge	Ly Ave	enue,	Annapo	lis, M	D 214		
			23a. Part T. Enter the disease shock, or heart failure.	e, or dehp List only o	one cause on e	caused the death each line.	. Do not ent	er the mode of dyin	ig, such as o	cardiac or r	espiratory arre	st,		Approximate Interval Bety Onset and D	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a		2/2	410						1000	17.
	Examiner				Due 10	(er as a consequ	derice or).								
	₽ ≒	ner	Sequentially list conditions, if any lagon to immediate cause. Enter Underlying Cause (Disease or injury	J	Due to	or as a consequ	uence of								
	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last		c. Due to	(or as a consequ	ieuce of).						_		
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9	tificate to g physical as the t	ledic			d								7-		
Вох	death certifica attending ph d for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnar in the past 12 months?	t		itcome of pregnal		Ectopic pregnancy	,			1	Date of deliv	,	'ear
O. E	it the dea by the at tached fo	ysici	1 Yes 2 No 9 Unknown		4□Pregi 9□Unkn	nant at time of de lown	eath 5	Other (specify)				lv	ionin	Day 1	eai
۵.	de ed		Part II. Other significant co	nditions co	ontributing to d	leath but not resu	ulting in the u	nderlying cause giv	en in Part I.		23e. Did toba	acco use co	ntribute to !	the cause of d	eath?
rds,	w requires been sign should be	ed by									1 🗆 Yes	2 🗆 No	3 🗌 Prol	bably 4 🖯	Inknown
Vital Record	e law re has bee je 2 sho	Completed									24a. Was an autopsy	24b	). Were auto	opsy findings a	available
Œ.		Com									perform	ed? ☑ No	death?	2 No	2000 01
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to me examiner?		Hospital:			t all pos Oth	05		Check only one				
of	Phys r this ral dii	. To	1 ☐ Yes 2 ☐ No 27. Manner_of Death		28a. Date	of Injury	ER/Outpatier 28b. Time o	IL 3 DOA	4 🗀 INUI		<ul> <li>5 Resider</li> <li>d. Describe how</li> </ul>			fy)	
ion	Attending Phideath. ctor: After thi	atior		ending vestigation		nth, Day Year)	Injury		k? Yes 2∐N	No					
Division	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the fune	Certification;		ould not be stermined	28e. Place build	e of Injury - At ho ling, etc. (Specify	me, farm, st	reet, factory, office	/	28	f. Location (Street, City or Town,		nber or Run	al Route Num	ber,
	Hospital 24 hours a Funeral C		29a. Certifier 1 Cer	tifying Ph	vsician: To the	e best of my know	wledge, deat	h occurred at the tir	ne. date and	d place, an	d due to the car	use(s) and n	manner as s	stated	
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	(Check only 2 Me	lical Exam	iner: On the b	pasis of examinat nner stated.	tion and/or in	vestigation, in my o	pinion, deat	th occurred	at the time, da	te and place	and due t	to the cause(s	)
	To the within 24	Σ	29b. Signature and title of co	ertifier	12 DA	_	14.0	29c. Licens	e number	19	29	d. Date sign	ned (Month,	Day, Year)	00 21
	d.		11-400	//	v~0	/	NO	102	( 0	(	p	1400	h 2	-12	2
	17		30. Name and address of pe	1	·M	9/13	132	Print) Holide	5 0	T, S	-ite	201	A~	apolis	2
	Sta Regist	ate rar	31. Date filed (Month, Day, MAR 22	2004	Sen	Registrar's Signa		sparks						•	

		•	For State Registrar	State of Maryland		tment of F ificate of		мепіаі ну	glene Reg. No. 200	4 09012
	Physicia /Medic	an al	Decedent's Name (First, Middle, Last,		G'	roner		2. Date of De Month Marc	h 14 2009	1 11:11 A M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give  JOHNS HOOKINS BAY  5. Social Security Number  220-38-8243	View Medical C	enter st birthday) Yrs.		HOURT HOURS HOURS Min.	8. Date of Bir (Month, Da	ay, Year)	Sirthptace (State or Foreign Country) aryland
A Sh	D		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	Maryla	to	Maryland Baltimo:	re Fo	rt How	ard				1 🗆 Yes 2 🔀 No
	or 28s	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
0	2 should be filed within 72 hours after death with the Maryland and Menth Hygiene.  Is marked other than "natural; or Items 23e or 28e-f show armatic event, it is Medical Evants are must be notified at	Funera	9208 Todd Avenue  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 [X]No			-0021 lispanic Origin? (San, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	United Storm 14. Race - Ar Black, W Specify:	merican Indian,
21215-0036	72 hours a natural', o dical Evan	eted by	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	If Yes, Give Year or Dates:	16a. Decede	ent's Usual Occup	ation during most of wo	rking	16b. Kind of Busine	
ณ	er than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) +3	life. D	O NO I use retire	rity Spe	cialty_		Government
Maryland	ould be filed with Mental Hygiene Brked other than Bilc event, I is 1	Be	17. Father's Name (First, Middle, Last)	Tr				ne <i>(First, Middle</i> Harrisor	n, Maiden Sumame)	
	should nd Mei mark mark	ဥ	George D. Spicer,  19a. Informant's Name/Relationship (T)		19b. Mailing	Address (Street			er, City or Town, State	a, Zip Code)
	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic av <u>pnce</u> .		Harvey H. Groner  20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗆	20b. Pla cer Removal from State	nce of Dispos	8 Todd A ition (Name of atory or other plan alley Me	ce)	Date	rd, M. 2 20c. Location - City 4 TimOnii	or Town, State
Baltimore,	permit. Pa Departmen Important any injury		4 □ Donation 5 □ Other (Specify,     21. Signature of Fun ral Service Licens		Du	Name and Addre da-Ruck	ss of Facility Funeral	Home of	Dundalk, I	Inc.
₩.	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause do el ch line.	Do not ente	r the mode of dyin	ng, such as cardia	c or respiratory a	arrest,	Approximate Interval Between Onset and Death
8760,	Examinet be executed by physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Declared over 1917) that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.)  Due to (or as a consequence.)	ence of):	clot ent t	en-r	onu		
.O. Box 68	death certif e attending id for use as	by Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dei	death 3 🗆	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
s, D	se Es		Part II. Other significant conditions co	ontributing to death but not resul	Iting in the un	dertying cause gi	ven in Part I.			e to the cause of death?  Probably 4 Xunknown
Il Record	The law ate has b page 2 sl	Completed						24a. Was auto perf 1 Yes	opsy prior death	autopsy findings available to completion of cause of ?? 'es 2 \( \) No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 🗷	R/Outpatien	3□ DOA Ott	200	ath (Check only	one) idence 6 □Other (S	(necify)
of	ng Ph Ifter th Ineral	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo			how injury occurred	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
	e Hospit 124 hour e Funera letely fille	Medical (	29a. Certifier 1. Certifying Ph (Chack only one) 2 Medical Exam	ysician: To the best of my know liner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the trestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time	a cause(s) and manner , date and place, and o	as stated. due to the cause(s)
)	To the To the complete	Me	29b. Signature and till of denifier			29c. Licen	se number	2	29d. Date signed (M	onth, Day, Year)
•	20		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)		>	7(13 C	16 - 3-16
1	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat		E0340	m Alan		1 timore 1	1) 21224

ORIGINAL

09013 State of Maryland / Department of Health and Mental Hygien ) 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** March MICHAEL 16,2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner maryland General Hospital Baltimore
If Under 1 Year If Under 24 Hrs. N/A Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 . K 2 . F **51**Yrs. Dec 29, 1952 219-56-2608 Director Usual Residence of Decedent with the Manyland 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Extraction related by notified at 1 **2** Yes 2 □ No MD Director N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21218 1611 Nothgate Road death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black and 21215-0036 3 Widowed 4 Sivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) M.T.A. Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental. Camp Freemond Griffin Ruth 2 Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Miss Kellie Mackey-Daughter 2504 Yorkway, Baltimore, MD 21222 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o Mar 22 1 Burial 2 Femation 3 Removal from State 2004 \$460 MD 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CROMPTORY 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Calvin L. Williams Funeral Home, P.A. 2.1 clou 2818 East Baltimore Street Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEDSL **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine certificate be executed and buriai-trar Due to (or as a consequence of): Box 68760, physicien Physiclan/Medical the as the attending IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lor 1 in the past 12 months? Month Dav Year 5 Other (specify) ☐Yes 2☐No o 9☐ Unknown detached 9 Unknown signed by ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ þe 3 Probably 4 ☐ Hiknown 1 ☐ Yes 2 ☐ No Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page 5 autopsy performe 1 Yes 2 D No Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 | Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ( No 2 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA ō this filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: After Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral C t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified ٥ 16/04 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 BAXTIMORE 21201 AVE MD ONWIKA LINDEN HIKE 31. Date filed (Month) Dan, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

MARO

-2004

			1 - Stateamend item 11 per Registrar	State of Maryland exwife g839 1/31	d / Depa -/05 <i>cei</i> rl	rtment of H	ealth and M Death	ental Hygi	ene 2001	+ 09014
	. ~		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic	_		David A	11en	Henson		3	18 2004	5:25aM
	Examin		4a. Fecility Name (If not institution, give st			4b. City, Town, or	Location of Death		4c. County of Dea	ath
			3908 Liberty He:			Balto	If Hadas 04 Hes		N/A	at the Court of Francisco
	Funeral		5. Social Security Number 6. Sex 1215-16-0940	M 2□ F 7. Age (In yrs. la	ast birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, 6 29	Year) 1922	nthplace (State or Foreign country) Md
	Director	}	Usual Residence of Decedent	01				0 27	1)22	rid
	yland		10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
	a-f e	cto	Md N/A	Ва	1to					1X Yes 2 No
	th the or 28	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of What C	country?
	23e	ral	3908 Liberty He:			21207	0.:0./0-	-4-WN-	USA	orican Indian
36	s within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f ehow the Medictal Examinar must be trafffied at	by Funeral	11. Marital Status  12 Never Married 2 Married  3 Widowed 4 XX vorced	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>May Yes 2 □ No If Yes, Give Year or Dates;</li> </ol>	If	Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
21215-0036	2 hours	ed	15. Decedent's Educ	ation	16a. Deced	ent's Usual Occupa	ation during most of work	ina	16b. Kind of Busines	
215	- 51	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	)	ng	C & P Te	elephone
21	filed within Hygiene. other then	Son	12th grade	N/A	Appa	aratus Wo			0	
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yla		2	Daniel Henson		121 14 19			Howard	City as Town State	Tie Code)
Maryland	2 sh and ie m raum	1	19a. Informant's Name/Relationship (Typ						City or Town, State,	
	is 1 and 2 should of Health and Meritem 27 is marks other traumatic		Gregory Henson - S	20b. P	lace of Dispos	sition (Name of			Balto, Md 20c. Location - City o	
آور	0 0 -		1 ☐ Burial 2√☐ Cremation 3 ☐ Re			natory or other plac rematory	3/19	/04	Catonsvil:	le, Md
Baltimore,	그 돈 뿐 글		<ul> <li>4 □ Donation  Other (Specify)</li> <li>21. Signature of Funeral Service Ligense</li> </ul>	9	22	Name and Addres	ss of FacilityMar	sh E/H	West	
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	/Medical		disease or condition resulting in death)	Due to (or as a consequence	uence of):	relian				Transport of
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8760,	icate be ex physicien s the burial	dlcs	<b>—</b> d							
Box 6	ath certifi attending for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year
P.O.	that the de ed by the detached	hys	9 □Unknøwn	9□ Unknown						
Records, F	w requires that the been signed by t should be detach	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tot		to the cause of death?  Probably 4 Unknown
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'ita	ician: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	θ)	
× ×	Physician: rthis certific ral director,	2	1 ☐ Yes 2 ☐ NO		ER/Outpatien		4 Industry no		ence 6 Other (Sp	pecify)
n	19 e	i.i.o	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe no	ow injury occurred	
Division of Vital	Attending in death.  ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	ome farm str		163 2 110	28f. Location (St	reet and Number or i	Rural Route Number,
.≥	after Direction by	ertif	4 Homicide determined	building, etc. (Specif	(y)	oo, 1200, y, 0		City or Town	n, State)	
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical C	29a. Certifier 1 Certifying Physical Check only 2 Medicel Exeminates	sicien: To the best of my knoner: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred at the tirvestigation, in my o	me, date and place, ppinion, death occur	and due to the cred at the time, d	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Mo.	nth, Day, Year)
	⊢ s ⊢ o		Banalela	in MN		D47	749		3/19/04	
	ί, Χ		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type,	Print)	1120		1.11	
	Y		Fern Jeffries M	0 2435 W.	Belved	ere An	m #22	Boltimar	e MO 242	15
		ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	100 a			,	
	Regis	ırar	MAD 9 9 2000	1 Marian d	The state of	100				

		-	For State Registrar	\$	State o	of Mary	land		ırtment <i>tificate</i>			and M	ental Hy	giene Reg. No.		09015
Š,	W 20	21.5	1. Decedent's Name (First, Middle	, Last)									2. Date of De Month	ath Day	/ Year	3. Time of Death
	Physicia /Medic		Mildred				H	Iudso					MARCH	1 1-	1 2004	
	Examin		4a. Facility Name (If not institution		eet and no	ım <i>ber)</i>					Location o	of Death		4c.	NA County of Death	1
78.		49	Union Mem. Ho			7. Age (In	um lan	t hirthday)			more If Under	24 Hrs.	8 Date of Bir	db.		place (State or Foreign
	Funeral		5. Social Security Number 219–32–9483	6. Sex	4 2 <b>∑</b> F		yis. iasi	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Date 1-27-		Cot	la.
Ter is	Director		Usual Residence of Decedent			68							1-2/-			
	yiand yiand		10a. State 10b. County			100		Town or Lo								10d. Inside City Limits
	a-fsh	ctor	Md.	N	A		F	Balti								1 No 2 No
	or 28	Director	10e. Street and Number						10f. Zip		010			10g. Cit	izen of What Co	untry?
	ath w		11 W. 20th St					40.1	Mar David		218	ining (Cod	od. Voc of N		USA 14. Race - Amer	ican Indian
	ltems nern	Funerai	11. Marital Status		Armed F	cedent Ever orces?	r in U.S.	13.	Yes, spec	rify Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)		Black, White	
36	ours after death with the Marylan raf, or Items 23a or 28a-f show Expullier must be rodified at	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	100	If Yes, G Year or	2v No live Dates:			1 ☐ Yes	No No	Specify:				Specify: Bl	.ack
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<u>a</u>	d 2 sl th an th an treur				aught	or							ilda.,			
စ်	Heal Heal tem 2		Carole Smith 20a. Method of Disposition			2	20b. Plac	ce of Dispo	sition (Nan	ne of		[	ate	20c. L	ocation - City or	
<u>o</u> L	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (5		moval fror	n State			nt Ce			3-20-	04	Ba	ltimore,	Md.
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any njury or other treumatic e 2005.		21. Signature of Funeral Service		)			22	2. Name an	d Addres	ss of Facili	ty	В	alti	more, Mo	1. 21202
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la			23a. Part1. Enter the disease, or shock, or heart failure. List	complications only one	ations that cause on	caused the each line.	death.	Do not en	er the mod	e of dyin	g, such as	cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
333	Physician		Immediate Cause (Final disease or condition	a	P	ulmon	nar	ч	Embe	lis	m					few hours
	/Medical Examiner		resulting in death)		Due to	o (or as a co	eupeano									
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<u> </u>	Physicien: The I r this certificate ha ral director, page	To B	examiner? 1 □ Yes 2 No	Ho	spital:	Inpatient	2 🗆 E	R/Outpatie	nt 3 DC	Oth Oth	er: 4 🗆 N	ursing Ho	me 5 Res	sidence	6 □Other (Spe	oify)
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sio	Attending it death.	cati		igation	00 01		41.5		M		Yes 2□	No	281 Location	/Street a	nd Number or Pi	ıral Route Number,
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	To the Hospitel or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledicai Ce	29a. Certifier 12 Certifyi (Check only 2 Medica	ng Physi I Examin	er: On the	basis of ex	caminatio	ledge, dea on and/or in	th occurred nvestigation	at the tin	me, date a pinion, de	nd place, ath occur	and due to the red at the time	e cause(s ), date an	s) and manner as d place, and due	stated. to the cause(s)
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	F 3 F 8		Dama M				(	, , (	F	T	243	891	16	MA	RCH . I	7,2004
			30. Name and address of person	who cor	npleted ca	ause of deat	th (Item 2	23a) (Type								
			SAPNA MAR				UNI	or w	( Elain		- H(	1 420	LHL, b	SHL	TIMOR	, "
	St Regist	ate rar	31. Date liled (Month, Day, Year		32	. Registrar's	Signatu	te p	pork	24						

DHMH 17 Rev 1/2001

ORIGINAL

20An Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MONTH CH DAY 9, 2004 **Physician** Thelma Hunter /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deat Examiner Mercy Hospital Baltimore NA If Under 1 Year 5. Social Security Number If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**X**]M 2□ F 55 Yrs. 218-44-1315 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural; or itema 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at No Yes 2□ No Funeral Director Md. NA Baltimore 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 335 S. Ballou Ct. 21231 USA THELMA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "n any injury or other transmets." Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Nurse's Aide Varies 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roosevelt Richardson Ella Phillips 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1520 Hollins St., Baltimore, Md. Leonette S. Robinson 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ND Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. 3-23-0 Lansdowne, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Baltimore, Md. La Warre March F.H. east 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Curce Examiner Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Sequentially fist conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2□ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify edical Certification: To 1□ Yes 2□ No 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Director: After 5 Pending investigation 1 Natural 1 TYes 2 □ No death. 6 Coufd not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \[ Homicide within 24 hours a

To the Funeral C

completely filled 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D40854 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

MAR 2 2 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item # 10c, per FH, G829, 3/22/2004, gap Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician LEXANDER 11:05 AM WARCH 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMIRE REHABILITATION EXTENDED CARE

5. Social Security Number

6. Sex.

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Months Days 20-38 Min. Hours Director 0 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE or 28a-f show other traumatic event, the Madical Exeminer must be notified at 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Yes, Give Year or Dates: Specify. Completed by act 3 Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic avent (Give kind of work done during most of working life. DO NOT use retired) Elementary/Se ondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be 1/2 HARRISI ٩ lliam 4 OL 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ro MO21244 Dalio 3308 Laur 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Garrison 3-25-04 ()WINE ( Trest 21. Signature of Funeral Service License 22. Name and Address of Facility Wel LIBERT 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CHRONIC OBSTRUCTIVE LUNG DISEASE, END **Physician** /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760. the attending physicien by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 2 🗆 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes 2 No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: P 2 ER/Outpatient 1 Inpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \[ \text{Homicide} Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number an,

State Registrar

0

2 2004 DHMH 17 Rev 1/2001

Date filed (Month, Day, Year)

32. Registrar's Signature

BOULEVARD

mpleted cause of death (Item 23a) (Type, Print)

390 LOCH PAVEN

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'		1	For Unpend Item #2	State of Ma	ryland 8 Depa	tificate of	lealth and l Death	Mental Hyg	2004	09018
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	nysicia	n		DRICKSON				Month	Day Yeer 14, 2004	0849 A M
	Medica xamine		4a. Facility Name (If not institution, give st.			4b. City, Town, o	r Location of Deatl		4c. County of Deeth	
	. airiii i		1113 Singer Drive			Westmin	ster		Carroll	
Fu	neral		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	nplece (State or Foreign untry)
	ector		215-68-7690	M 2X F	47 Yrs.	Mortins Days	Hours Min.	JAN. 26,	1957 WAST	TINGTON, DC
and	-	-	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
Aaryl	a La	ठ	MD CARROLL		WESTMI	VCTED				1 ☐ Yes ZX No
the the	ito	Director	10e. Street and Number		WESTRIL	10f. Zip Code			10g. Citizen of What Co	untry?
death with the Maryland	4	ੂ	1113 SINGER DRIVE			21157			USA	,
eath	TTIME	Funeral		2. Was Decedent B	ever in U.S. 13.	Was Decedent of H		pecify Yes or No-		ncen Indian,
ē #	ices	5	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ N	lo.			o Ricen, etc.)	Black, White	e, etc.
vithin 72 hours after ene.	Exam	þ	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊉No	Specity:		Specify: WH	IITE
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2 de vi	ם	5	12	Ø	M	ANAGER			BAKERY	
nd 2	S .	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
should be		၉	ANTHONY PAUL ZUKOS	KY			HEL	EN YASEN	CHOK	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiens.	other traumatic		19a. Informant's Name/Relationship (Type						r, City or Town, State, Z	
and and and	in it		GREGORY HENDRICKSO	N / SON			RIVE, WE		R, MARYLAND	
Baltimore, permit. Pages 1 au Department of Hea	any injury or other tra		20a. Method of Disposition 1   ↑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of Dispo cemetery, crei	isition (Name of matory or other plac	ce)	Date	20c. Location - City or 1	Town, Slate
Pages ment of	ru)		`4 ☐Donation 5 ☐ Other (Specify)		IVY HILL	CEMETERY			LAUREL, MAR	
Balt permit. Depart	y in	1	21. Signature of Funeral Service Licenses	//////	255	2. Name and Addre			NERAL HOME,	
ш «а.	aa	4	Suphanie						UREL, MARYL	
	20		23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each lin	the death. Do not ent e.	er the mode of dyin	ng, such as cardiad	or respiratory arr	rest,	Approximate Interval Between Onset and Death
Physi			Immediate Cause (Final disease or condition	Diphenh	ydramine l	ntoxicat	ion			0.001 0.00 0001.
/Med Exam			resulting in death)	Due lo (or as a	a consequence of):					
- LAGII		_	Sequentially list conditions, b.	Place by Manager	or a second seco					
D.	tis .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se	i consequanca of):					
ecut	tran	хап	that initiated events c. resulting in death) Last	Due to /or as a	a consequence of):				-	
760, te be executed	2 2	calE		240 (0 (3)	2 00/100420/100 01/.					
<u> </u>	<u> </u>		d.							
I Records, P.O. Box 68 The law requires that the death certifica	Se S	Physician/Medi	IF FEMALE: 23	c. If yes, outcome	of pregnancy				23d. Date of deli	uan.
Box eath cert	foru	lan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetel death 3	Ectopic pregnancy Other (specify)	1		Month	Day Year
o g g	ched.	ysic	1  Yes 2  No 9 <b>3</b> Unknown	9□ Unknown		3 01.10. (0,000.)/		<u> </u>		
or at a	ld be detached i	4	Part II. Other significant conditions cont	ributing to death bu	Il not resulting in the u	ndertying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ds	od b	Completed by	Infectious Perica	rditis				1 🗆 Y	es 2 No 3 Pro	bably 4 Unknown
	should	ete						24a. Was a	an 24b. Were au	onsy findings available
<b>8</b> in 18	page 2							autops perfor	med? death?	topsy findings available ompletion of cause of
Vital F vicien: Th	or, pa		25. Was case referred to medical				00 Disease ( Day	15XYes		2 No
	rect	00	examiner?	spital:	nt 2 ER/Outpatier	y all poor Oth	00	th (Check only or	ence 6 <b>X</b> Other (Spec	At Coope
P P	aral d	2	27. Manner of Death	28a. Date of Injur	y 28b. Time o				ow injury occurred	My At Scene
O ding	fune		1 Natural 5 Pending 2 Accident Investigation	Found Month, Day	Found		k? Yes 2.∭ZNo	Unknown		
Division of Vital Records, P.O. tor Attending Physicien: The law requires that the dark attendeshing properties that the director after this continue has been signed by the	y the	<u>=</u>	3 ☐ Suicide 6 ☑ Could not be	28e. Place of Inju	iry - At home, farm, sti (Specify)		**		treet and Number or Sun, State)	ral Route Number.
Div A	din	Certification;	4  Homicide determined	Resider				Westmins	ster, Md	inger br.
Division of Vital Hospital or Attending Physicien: Funcasi Disector, Affect this confined	y fille			cian: To the best o	il my knowledge, deat				ause(s) and manner as	
n 24	completely filled in by the funeral director.	Medical	(Check only 2X Medical Examinations)	er: On the basis of and manner sta		vestigation, in my o	pinion, death occu	irred at the time, o	late and place, and due	to the cause(s)
To the within 2	com	Σ	29b. Signature and title of certifier			29c. Licens		2	29d. Date signed (Month	
1 01	2,		) auesl			0.C.	М.Е.		March 15,	2004
1800	/		30. Name and address of person who con	pleted cause of de	eath (Item 23a) (Type,	Print)				
1 1	1		ANNA KUBI	O, MD		111 Penn	Street,	Baltimo	re, Marylan	d 21201
//			/1/01, 1-0.7.							
	Stat egistra		31. Date filed (Month, Day, Year)  MAR 2 2 2004		ar's Signature	Ana K				

DHMH 17 Rev 1/2001

ORIGINAL

Dexter Hill Unknown 04-081 04-01925 cm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 00009019 1- State Registra-AMEND ITEM #19b PER FH G829 3/22/04 Gentificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician** DEXTER HILL March 17 2004 P' 11:48 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. 1510 N. Bethel Street 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **№** М 2 🗆 F Director 37 214 04 1938 6,1967MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event. The Medical Examiner must be notilised at 1√2 Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 609 LUZERNE 21205 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No þ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10TH CARPENTER TOWSON PAINTERS permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked other any injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RUFFIN HILL ETHEL BELL b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2802 SPELMAN ROAD BALTIMORE, MD. 21225 19a, Informant's Name/Relationship (Type, Print) SHELBY WHEELER (FIANCE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State VOSHELL CEMETERY 4 □ Denation 5 □ Other (Specify) 03/26/04 BALTIMORE, MD. nomiture of Funeral Service Licenses CANTO IN Address of SCHRUGGS once. FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) Examiner 5 submitted by list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and ned for use as the burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Division of Vital Records. should be 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No has autopsy performed 2 No 2 🗌 No Yes 25. Was case referred to medical examiner?

1 💢 Yes 2 🗆 No Be 26. Place of Death (Check only one) Hospital: Other: ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) at scene 27. Manner of Death 28a. Date of Injury (Month, Pay Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 33 1 Natural 5 Pending investigation het Stat 30 death. 104 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 4 Aomicide 28e. Place of Injury - At hor building, etc. (Specify) 28f. Location (Street and Number or Rur | Route Number, City or Town, Stat.) - At home, farm, street, factory, office 0 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 2 296. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 18, 2004 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 J. Laron Locke M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 2 2 2004

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Frank

5. Social Security Number

217-88-8842

Usual Residence of Decedent

1 Decedent's Name (First Middle Last)

4a. Facility Name (If not institution, give street and number,

Hocpital

Iwaniw

0

1**X**XM 2□ F

Baltimore

7. Age (In yrs. last birthday)

53

Yrs

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min.

Baltimore

Year

2004

4c. County of Death

2. Date of Death Month

8. Date of Birth (Month, Day, Year) June 9, 1950

0

0	9	0	2	0
3	Time	a of	Deal	th

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Dav

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Month

1 Tes

1 ☐ Yes 2 √ No

Maryland

9:20 AM

Physician	
/Medical	
Examiner	

**Funeral** Director

of 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 27 le marked other then "neturel", or items 23e or 28a-f show treumetic event, the Medical Examitational Legistrial at permit. Pages 1 and 2 st Department of Health and Important: If item 27 len any injury or other treum once.

Baltimore, Maryland 2121

Kunn as

**Physician** /Medical Examiner

Examiner burial-transit physician the esn

10c. City, Town or Location 10a State 10b. County Director Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 24 Taxi Way 21220 United STates Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2√ No If Yes, Give 1 ☐ Yes 2CXNo Specify: Specify: White If Yes, Give Year or Dates: à Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked N/A 0 17. Father's Name (First, Middle, Last)
Michael Iwaniw 18. Mother's Name *(First, Middl*e, *Maiden Sumame)* Marilyn Walker Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anna AMbrose (Aunt) 24 Taxi Way Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 3/20/04 Brooklyn Park, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig Tre of Funeral Service Licensee 22 Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SVHDRAME 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown disorder Seizure 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Language 1 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 № No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Box 68760. P.O. | of Vital Records. Completed 2 Prospitel or Attending Pathous after death.
Funeral Director: After to Division To the Hospitel within 24 hours a To the Funeral D State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who complete

GARRIELA 31. Date filed (Month, Day, Year)

**ORIGINAL** 

Hospital

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SZABOITO

				State of Ma	Ce	Timeate of	Dealli	_		104	0302
	Physic	ian	Decedent's Name (First, Middle, III)	Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi Examir		Mildred 4a. Fecility Name (If not institution, c	Ar	nn		nson Location of Deatl	March	15 2 4c. County		9:40a.
	Lxaiiii	lei	5004 Cordelia			Baltimo			10. 000111	OI DOG!!!	
	Funeral			Sex 7. Age	(In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	h v. Year)	9. Birthpl	ece (State or Foreign
I	Director		220-48-0895 Usual Residence of Decedent	1 □ M 21 F	78 Yrs.	Jay 5	110013	10 3		M	
land	A H		10a. State 10b. County	I	10c. City, Town or L	ocation				10	Od. Inside City Limits
Магу	1	to	MD NA		Baltimo	re					XXYes 2 □ No
th the	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	ry?
death with the Maryland	ral, or itams 23a or 28a-f show Examinar roust be notified at	rai [	5004 Cordelia	Ave		212	15		U.	S.A.	
	itams Dar D	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Rac Blac	e - America k, White, e	
0036 hours after	I, or	by F	1 ☐ Never Married 2 ☐ Married  1 ☐ Widowed 4 ☐ Divorced	f 1 ☐ Yes XIXNo If Yes, Give Year or Dates:	0	1□Yes 2X No	Specify:		Specify		1-
5-0036 72 hours af	natural',		15. Decedent's	Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu		ack
<b>2</b> ig		Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+	life.	kind of work done of DO NOT use retired	during most of wor  )	king			,
2 %	ygien har th	S	12th grade	na	Н	ousewife			Hom		
Maryland	ad of	Be	17. Father's Name (First, Middle, La	st)			18. Mother's Nan		Maiden Sumam	10)	
Though	nd Mental Hygiene. marked othar than matic avant, tre M	2	Eugene Gough  19a. Informant's Name/Relationship	(Type Print)	10h Maili	ng Address (Street a	Sadie		City or True	C1-1- 71-	
Mar nd 2 sho	27 is r trau		Sadie Ann Joh	, , , , ,							
s 1 ar	Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo	04 Corde osition (Name of matory or other place		Date	20c. Location -		21215 vn, State
	nt: If i		1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Special Control C			norial P	1	0/04	Dandal	1	M-J
Balti Sermit.	Department of Hea Important: If item any injury or othe once.		21. Signature of Funeral Service Lie	ensee .	King Hei	2. Name and Address arch F/H	is of Facility	.0/04	Kanual	ISCO	vn, Ma
<b>m</b> &	Deg in a		Jebec Pr	-0-	2 43	300 Waba	sh Ave,			d 2:	1215
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nted	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, it is that initiated events.		ARICI	ALCO	the	7715	SAR	=	Darring
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S/DU,	ohysician and the burial-transit	dical		d							7/.
ertilic X	ling pl	0	IF FEMALE:			_					
DOX	attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date Mor	e of deliver	/ Day Year
) at	the	ysic	1 Yes WNo 9 Unknown	4□ Pregnant at ti 9□ Unknown	me of death 5	Other (specify)			(410)		ay roar
that	signed by d be detac		Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contri	ibute to the	cause of death?
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Ö	should	ete		De e l	,						
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The law	has Fe 2	dmo	Darael	le cus i	rus C	ll cers		24a. Was a autop perfor	med? p	rior to com eath?	y findings available pletion of cause of
ITAL RECORDS, P.O. BOX 68/6U, ian: The law requires that the death certificate be executed	ate has page 2	3e Completed	25. Was case referred to medical	Ide aus i	ris C	ll cers	26. Place of Deat	autop perfor 1 Yes	med? d	rior to com eath?	sy findings available pletion of cause of
VITA sician:	is certificate has director, page 2	To Be Comp	25. Was case referred to medical examiner?	Hospital: 1 Inpatient		U Cers	26. Place of Deat	autop perfor 1 Yes	pmed? d 2 No 1	rior to com eath? Yes 2	oletion of cause of
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OT VITA Physician:	n. After this certificate has funeral director, page 2	To Be	examiner?  1 Yes 24 No  27. Manner of Death  14 Natural 5 Pending 2 Accident investigati	1 ☐ Inpatient  28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	28c. Injury Work M 1 Y	r: 4 Nursing Ho	autop perfor 1 Pes h (Check only or ome 5 Resid 28d. Describe h	sy p med? d 2 No 1 1e) ence 6 □Othe ow injury occurre	rior to comeath?  Yes 2  or (Specify)	oletion of cause of
Or Attending Physician:	irier deain. Diractor: Affer this certificate has in by the funeral director, page 2	To Be	examiner? 1 Yes 220 No 27. Manner of Death 120 Natural 5 Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	28c. Injury Work M 1 Y	r: 4 Nursing Ho at ?	autop. perfor 1 Yes  h (Check only or	med? pmed? 2 No 1  ne)  ence 6 Othe ow injury occurre	rior to comeath?  Yes 2  or (Specify)	oletion of cause of
LIVISION OF VITA  I or Attending Physician:	irier deain. Diractor: Affer this certificate has in by the funeral director, page 2	Certification: To Be	examiner?  1  Yes  242 No  27. Manner of Death  142 Natural  5  Pending investigati  3  Suicide  6  Could not determine	28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury  y - At home, farm, str (Specify)	f 28c. Injury Work M 1 1 Y eet, factory, office	r. 4 □ Nursing Ho at ? 'es 2 □ No	autop- perfor 1  Yes  h (Check only or me	reet and Number, State)	rior to comeath?  Yes 2  or (Specify)  ed  or or Rural i	oletion of cause of  No
Hospitel or Attending Physician:	24 nou's arier deam. Funeral Diractor: After this certificate has itely filled in by the funeral director, page 2	Certification: To Be	examiner?  1 Yes 22 No  27. Manner of Death  12 Natural 5 Pending investigati 3 Surcide 6 Could not determine  29a. Certifier 12 Certifying-F	28a. Date of Injury (Month, Day)	Year)  28b. Time of Injury  y - At home, farm, str (Specify)  my knowledge, death xamination and/or in-	28c. Injury Work M 1 Y	at ?  'es 2 \sum No	autopperformation in the control of	per and Number, State)	rior to comeath?  Yes 2  or (Specify)  ed	□ No □ No □ Route Number,
Hospitel or Attending Physician:	arter dearn.  Diractor: After this certificate has in by the funeral director, page 2	To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigati 3 Suicide 6 Could not determine  29a. Certiflier 1 Certifying-F (Check only 2 Medical Exc	28a. Date of Injury (Month, Day on be d 28e. Place of Injury building, etc.  Physician: To the best of eminer: On the basis of e	Year)  28b. Time of Injury  y - At home, farm, str (Specify)  my knowledge, death xamination and/or in-	28c. Injury Work M 1 Y	e, date and place, inion, death occur	autopperform 1 Yes  h (Check aniv or ome Series Aresid 28d. Describe h  28f. Location (Series Area and due to the cred at the time, d	med? pd med? 22 No 1  22 No 1  109)  ence 6 Othe ow injury occurred and Number 7, State)  ause(s) and marate and place, a  9d. Date signed	refor to come ash?  Yes 2  or (Specify) ad  or or Rural in the ash and due to ti	Route Number,  ed. he cause(s)
Hospitel or Attending Physician:	24 nou's arier deam. Funeral Diractor: After this certificate has itely filled in by the funeral director, page 2	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not determine  29a. Certiflier (Check only one)  2 Medical Examination	28a. Date of Injury (Month, Day on be d 28e. Place of Injury building, etc.  Physician: To the best of eminer: On the basis of e	Year)  28b. Time of Injury  y - At home, farm, str (Specify)  my knowledge, death xamination and/or in-	28c. Injury Work M 1 1 Y eet, factory, office	e, date and place, inion, death occur	autopperform 1 Yes  h (Check aniv or ome Series Aresid 28d. Describe h  28f. Location (Series Area and due to the cred at the time, d	med? pd med? 22 No 1  22 No 1  109)  ence 6 Othe ow injury occurred and Number 7, State)  ause(s) and marate and place, a  9d. Date signed	refor to come ash?  Yes 2  or (Specify) ad  or or Rural in the ash and due to ti	Route Number,  ed. he cause(s)
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			For State Registrar	State of Man	yland.		artment o			nd M		iene <sub>eg. No.</sub> 2	004	09022
			1. Decedent's Name (First, Middle, Last	)							2. Date of Deal	h Day	Yeer	3. Time of Death
	Physicia /Medic		Lawrence			Joh	nson				3		2004	8:45a <sup>M</sup>
1	Examin		4e. Facility Name (If not institution, give				4b. City, To			Death		4c. Cou	nty of Deeth	
			Harbor Health Ca			4 to 1-44 - 45 - 11	Ba If Under 1 \	ltim		A Hrs	Doto of Bigh		NA Bisto	Inno (Ctata or English
	Funeral		5. Social Security Number 6. Se	≱M 2□F		t birthday) Yrs.			Hours	Min.	8. Date of Birth (Month, Dey,	Yeer)	Cour	• •
	Director		245-40-9223 Usual Residence of Decedent	78							5-3-25		J.S.	C
	land ow		10a. State 10b. County	10	0c. City, T	own or Lo	cation					0d. Inside City Limits		
	Mary I eh	to	Md. NA			Balt	imore							Y☐Yes 2☐No
	r 28s	Director	10e. Street and Number				10f. Zip Co				1	0g. Citizen	of What Cour	ntry?
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother then "natural", or tems 23e or 28e-f show event, the Medical Exatural institut to collified at	a D	817 Exeter Hall	Ave.			2	21218	3				USA	
	ems ems	Funeral	11, Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. \	Was Decedent f Yes, specify	nt of Hispa Cuban, I	anic Orig Mexican,	in? (Spe Puerto I	cify Yes or No- Rican, etc.)		Race - Americ Black, White,	
9	or It	y F.	1 Never Married 2 Married	1 X Yes 2 ☐ No If Yes, Give			1 ☐ Yes 2 🔀	No s	Specify:			Spe	<sup>cify:</sup> Bla	ck
ë	urel'	d by	3 Widowed 4 Divorced	Year or Dates:	1 4	162 Doors	dent's Usual C	Occupation	20				Business/In	
<u> </u>	n 72 nat	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	'	(Give	kind of work of	done duri	ing most	of workir		100. 11110 0	D03111033411	303(1)
21215-0036	withi ene. then	шс	Elementary/Secondary (0-12)  12th grade	College (1-4or 5+)		Labor	er					Bethl	ehem S	teel
<u> </u>	Hyg other	BeC	17. Father's Name (First, Middle, Last)					18	B. Mother	's Name	(First, Middle, I	Maiden Surr	ame)	
au	Menta Menta rked ric ev	To B	Norman	J	ohns	on			Idi	ne			Smith	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens.  Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examination must be notified at once.		19a. Informant's Name/Relationship (T								Route Number	-		
Σ	and 2 salth n 27 i		Linda Martin	Daughter					edere		., Balt			21239
ore	of He		20a. Method of Disposition 1 □ Burial 2 🎇 Cremation 3 □	ì	20b. Plac	e of Dispo etery, crer	sition (Name natory or othe	of er place)	i				on - City or To	
Ē	Pag ment ant:		` 4 □ Donation 5 □ Other (Specify		Gre		int Cem		1	3-24-	-04	Balt	imore,	Md.
Baltimore,	epart epart nport ny in		21. Signature of Funeral Service Licens	500	_		. Name and				Baltim			1202
	40 E = 0		23a, Part 1. Enter the disease, or comp	Wans	ر ا		larch F				1101 E		th Ave	Approximate
			shock, or heart failure. List only of	ne cause on each line.		2	~			ardiac o	i iespiiatory aii	931,		Interval Between Onset and Death
	Pnysician:		Immediate Cause (Final disease or condition resulting in death)	a. Vov			لاط خ	ech.	rec					
ut	/Medical Examiner	- 1		Due to (or as a d		70	. X	•	Dia	Ď.				
		e	Sequentially list conditions,	b. Oue to (or use a	tonsequer	ce cn	a Tors	-	500	120				
	nsit	E C	Sequentially list conditions, farry, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dia	usel	6								
Ć.	execin and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a c			. \				à = 1			
8760,	cate be executed oblysician and the burial-transit	edicai		o Grant	om	18hm	5 /2	lica	a	ui	to out	rurer	runs	
9	death certificate be executed e attending physician and od for use as the burial-transit	Medi	IC COLLE						alf	- 10 B	×c			
Вох	death certifica attending pt d for use as t	an/	23b. was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [			Ectopic preg	nancy					Date of delive Month	ory Day Year
	e dea he ati	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4⊟Pregnant at tiπ 9⊟Unknown	ne of deat	th 5 [	Other (spec	ify)				13	i vi Ci i u i	Day Tour
P.O.	law requires that the death as been signed by the atter 2 should be detached for u	Physician/M	9 Unknown  Part II. Other significant conditions co	antribution to death but t	not resulti	ng in the u	nderwing cau	ISA AIVAN	in Part I		23a. Did to	bacco usa c	ontribute to ti	ne cause of death?
JS,	w requires that been signed to should be det	by		alone		4	nitum	30 given	mir caret.			es 2 □ No		
Division of Vital Records,	requ	Completed	1000				10.00				04- 146	- 104	- Mars auto	- nu findings qualible
3ec	e law has t je 2 s	upi									24a. Was a autops perfor	Sy	prior to co death?	psy findings available mpletion of cause of
a	ate pag										1 Yes	2 1 No	1 🗆 Yes	2 No
ξ	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	٥СІС	3/0	nt 3□ DOA	Othor	1		(Check only or ne 5 ☐ Reside		Other (Canad	
o	Phys rr this aral dir	<b>—</b>	27. Manner of Death	28a. Date of Injury (Month, Day Y		8b. Time o	1000	c. Injury at Work?		and the same	8d. Describe h			<b>y</b> )
lon	th: :: Afte	tlor	1 Natural 5 Pending 2 Accident investigation		(ear)	Injury	М		s 2 🗆 N	No				
Vis	Atter	iflo	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At hom	e, farm, str	eet, factory, o	office		1	28f. Location (Si City or Town		mber or Rura	al Route Number,
Ö	s afte	Certification:	Tiomicide	bulldary, etc. (	(Spoony)							., 0.0.0,		
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of a	xaminatio	edge, deat	h occurred at	the time,	date and	d place, a	and due to the c	ause(s) and ate and place	manner as s	tated. the cause(s)
	the H iin 24 the F iplete	ledical	one)	and manner state	d.									
	To To	Σ	29b. Signature and title of certifier	711 - 2		€Y\)`		License n			2	-	ned (Month,	uay, rear)
,	x\		100	120		-		P 31		1			8/04	
	H		30. Name and address of person who	completed cause of dear			Print) Enla	کے	St	5.4	. 308	Ru	l 85	2 (MI) 2/20
			31. Date filed (Month, Day, Year)	32. Registrar's			ma	w		J. W.	2 -00	1 700	- VI ( PYW	V) -120
	Sta Registi		MAD 2 2 2004	General	4	1	medi	/						

ORIGINAL

			1 - For State Registrar	State of Mary		epartment Certificate			iene 2004	09023
	Physici /Medic		Decedent's Name (First, Middle, Last)     FRED	ERICKA M	. JA	СОВ		2. Date of Deat Month 03 - 1	h Day Year	3. Time of Death 6:33 P. M
jā:	Examir		4a. Facility Name (If not institution, give s VILLA ASSUMPTA AND	MARIA HEAD		N. B/	own, or Location of Dea			IMORE
	Funeral Director		5. Social Security Number 198-24-5635 6. Sex Usual Residence of Decedent	M 2007 7. Age (In	yrs. last birt	hday) If Under 1 Yrs. Months	Year If Under 24 Hr Days Hours Mir		Year) 1931 PEN	thplace (State or Foreign ountry) NSYLVANIA
	Maryland -f ehow	tor	10a. State 10b. County N/A		c. City, Towr	or Location BALTIM(	)RE			10d. Inside City Limits 1 XXXes 2 No
	h with the	al Director	10e. Street and Number 403 MARKLAND	AVENUE		10f. Zip C	ode 21212	11	0g. Citizen of What Co	•
036	urs after deat al', or itema : Examiner mu	by Funeral	11. Marital Status  XX Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1  Yes 2  You If Yes, Give Year or Dates:	r in U.S.	13. Was Deceder If Yes, specific	nt of Hispanic Origin? ( Cuban, Mexican, Pue (No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural', or itema 23a or 28a-f show springury or other traumatic event, I'm Medical Evans and Lie rolling an once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	16a.	life. DO NOT use	done during most of w retired)	orking UN	16b. Kind of Business	
/land	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) FREDERICK	JACOB			18. Mother's Na REGIN	ame (First, Middle, A A FRAUE		
, Man	and 2 sho ealth and in 27 ie ma		19a. Informant's Name/Relationship (Typ. SR. EDITHANN KANE	(SUPERIOR)	30	5 CABLE S	TREET, BAL	TIMORE, M	ARYLAND, 2	1210
altimore,	. Pages 1 Iment of H tant: If ite.		20a. Method of Disposition  1 ★ Surial 2 Cremation 3 Re  4 Donation 5 Other (Specify)	emoval from State	cemeter	Disposition (Name y, crematory or oth S OF NOTR			20c. Location - City or ILLCHESTER	
Bai	Depar Depar Impor eny in		21. Signature of Funeral Service License			RUCK TO	Address of Facility WSON FUNER		NC. TOWSON	
8760	Physician Medical Examiner physician and phy	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	mud insequence of CHYS insequence of	(SEDTICE. 1011: 11715 11715		ac or respiratory arre	St,	Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes XX No 9 ☐ Unknown	oc. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death	3 ☐Ectopic preg 5 ☐ Other (spec			23d. Date of deli Month	very Day Year
rds, P	quires that n signed b	þ	Part II. Other significant conditions conf	ributing to death but no	ot resulting in	the underlying cau	se given in Part I.	23e. Did tob.	acco use contribute to	
al Records,		Completed						24a. Was an autopsy perform	24b. Were au	topsy findings available ompletion of cause of
on of Vital	ng Phys dter this meral di	lon: To Be	27. Manner of Death  1 XX atural 5 Pending	ospital: 1  lnpatient 28a. Date of Injury (Month, Day Yes	2 ER/Out 28b. Ti	me of 28c	Other: 4 X Vursing Injury at Work?	ath Check on one Home 5 Resider 28d. Describe how	nce 6 Other (Spec	ify)
Division of	al or Attendi after death. I Director: A d in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, far	m, street, factory, o	1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one) XIX Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one) 20 Medical Examination (Check one) 20 Medical Examination	cian: To the best of my er: On the basis of exa and manner stated.	knowledge, mination and	death occurred at for investigation, in	he time, date and plac my opinion, death occ	e, and due to the car urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To T Com	Σ	29b. Signature and title of certifier  Manage L.	Jamet.		29c. L	icense number	29	d. Date signed (Month MARCH 22,	. <i>Day, Year)</i> 2004
	5		30. Name and address of person who con	ODY, MD.	7505	Type, Print) OSLE	2 \ 1. # 2	12 Tou	USON, M.	2/204
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 2 2004	32. Registrar's S	ignature A	Ann	» رب			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Margaret Beatrice Kirkwood March 18, 2004 8:30 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Nursing & Rehabilitation Center Westminster if Under 1 Year Months Davs 5. Social Security Number 7. Age (In yrs. last birthday) if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Days Hours Director 216-18-4949 78 June 29, 1925 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiene.
Important: If Item 27 is marked other than "netural" or item eny lijury or other traumetic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes ŽŽNo Carroll Maryland Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 Jessica Lee Drive United States Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ♥ No Specify: ģ Specify: White 3√2Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Banking 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Foll Margaret White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Hulcher-Smith (Daughter) 830 Jessica Lee Drive Westminster, Md. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 3/20/2004 Dorsey, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 art1. Enter the diseas shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physician end for use as the buriel-transit or Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68769 that initiated events resulting in death) Last Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Ibaillahan

23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings 24a. Was an autopsy completion of cause of death?

1 Tes 2 1 No 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Thursing Home 5 Residence 6 Other (Specify) 28b. Time of

1 Natural 2 Accident

à

Be Completed

Certification: To

Medicai

page

the funerel director,

completely filled in by

After

efter death.

Mospital 24 hours e Funerel D

To the within 2

28a. Date of Injury (Month, Day Year) 5 🗌 Pending investigation

28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Malcolmdine, Westminsh MD 211577

3 Suicide 4 Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and The

-0054218

29d. Date signed (Month, Day, Year) 03-18-2004

31. Date filed (Month, Day, State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reiman Janeur

32. Registrar's Signature

349

Registrar

			1 - For Amend Item	29d, per Dr,	3829; 3/2Z/Z	ortificate of	Death	Re	ierię <u>. O O r</u>	1 09025
	Dhysici		1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month	h Day Yea	3. Time of Death
	Physici /Medio		MARY	MONGER				MARCH	CI 200	
7	Examin		4a. Facility Name (If not institution,	give street and number)			or Location of Death	1	4c. County of De	ath
			NORTHWEST	HO=PITAL			ALLSTOWN		BALTIN	ore
	Funeral			5. Sex 7. Ag 1 □ M 2 【X F	e (In yrs. last birthda Yrs.	Months Days		8. Date of Birth (Month, Day,	Year) (	irthplace (State or Foreign Country)
	Director		218-12-0882 Usual Residence of Decedent		81 ""			03 21	22	VA
	yland		10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits
	death with the Maryland rms 23a or 28e-f show rmust by notified at	Director	MD NA		Baltin	ore				1XX es 2 □ No
	or 28	Olre	10e. Street and Number	Apt	: 12 <b>-</b> B	10f. Zip Code		10	g. Citizen of What (	Country?
	ath w	ral	3600 West Fra	anklin Str	eet Apt		21229		U.S.A	•
	er de Items	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - An Black, Wh	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ※ Divorced	d 1 ☐ Yes 2 <b>X X</b> If Yes, Give Year or Dates:	40	1 ☐ Yes XXNo	Specify:		Specify:	Black
ğ	2 hou	ted	15. Decedent's	Education	16a. Dec	edent's Usual Occup	pation	1	6b. Kind ol Busines	
215	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	life	e kind of work done DO NOT use retire	during most of world)	king		
7	ed wi	Con	9th grade	na	Do	mestic			Private	Homes
ğ	be fill	Be	17. Father's Name (First, Middle, La	(St)				ne (First, Middle, M		
2	d Mer narke	မ	Mermon Jones  19a. Inlormant's Name/Relationship	(Time Dist)	40. 11			a Tucke		
Maryland 21215-0036	d 2 s th an th an treur								City or Town, State,	
ē,	Hear Hem		Carl D. Monger 20a. Method of Disposition	<b>-</b> 5011	20b. Place of Disp	osition (Name of ematory or other pla	Ct, Rar		Oc. Location - City o	21133 r Town, State
E 0	Pages ent of nt: If I		Y Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spe				∞) Park 3/]		,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28e-f show my injury or other treumatic event, the Medical Esant retrinks to notified at once.		21. Signature of Funeral Service Lie		4	2 Name and Address RCh F		L0/04   F	Kandalis	town, Md
œ .	Depa Impo any ir		Dala	March	4	300 Wab	ash Ave,	Baltin	nore Md	21215
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused ity one cause on each lin	the death. Do not e	nter the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	me+	astic 0	astric	rarcinom	Ca.		Onset and Death
199	/Medical Examiner		resulting in death)	Due to (or as	a consequence of)					9
	3	-	Sequentially list conditions,	b. Due to for an	a ecinsaquanta of):					
	uted Insit	mlne	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	000 10 (51 00	a consequence on.					
o,	exection and ital-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):					
68760,	The law requires that the death certiticate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d						
89	ng ph		IF FEMALE:							
Box	ath ce ttendi	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth		☐Ectopic pregnancy	/		23d. Date of de	
o O	by the a	Physiclan/M	1 Yes 2 No	4☐ Pregnant at 9☐ Unknown	time of death 5	Other (specify)	-		Month	Day Year
Records, P.O.	that the ed by detac	, Ph	Part II. Other significant conditions	s contributing to death bu	it not resulting in the	inderlying cause giv	ren in Part I	23a. Did toba	cco use contribute t	o the cause of death?
S O	w requires that been signed should be det	d by			•	,			2 □ No 3 □ P	
Ö	w req	lete						24a, Was an	24h Wara a	utopsy findings available
Re	The lay	Completed						autopsy performe	prior to death?	completion of cause of
Vital		0	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 h (Check only one)	-	s 28 No
	Physician: this certition	To B	examiner? 1 ☐ Yes 2⊠ No	Hospital: Inpatier	nt 2 ER/Outpatie	nt 3 DOA Oth			ce 6 □Other (Spe	ecify)
Division of	ding Pl h. Atter ti tunera		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injun (Month, Day	Year) 28b. Time (	of 28c. Injur Wor	y at	28d. Describe how		
<u>s</u>	ttendi death. ctor: A / the tu	cat	2 Accident investigat 3 Suicide 6 Could not	ho			Yes 2 □No			
$\leq$	atter death atter death Director: , d in by the t	Certification:	4 Homicide determine	28e. Place of Inju- building, etc.	ry - At home, farm, si . (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
_	spital		29a. Certifier 12 Certifying	Physician: To the best o	f my knowledge dea	h occurred at the time	ne date and place	and due to the e-	ea/e) and marrow	s stated
	To the Hospital or Attending Physician: within 24 hours atter death: To the Funeral Director: After this certifical completely tilled in by the tuneral director;	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner stat	examination and/or ii	vestigation, in my o	pinion, death occurr	red at the time, date	e and place, and du	e to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			29c. Licens	e number	290	I. Date signed (Mont	h, Day, Year)
•	$\cap$		pratso	. m.D.		D	005973	6	MARCH 11,	2004
	1		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Type	Print)	-			
			DEBUAAH WATS: 31. Date liled (Month, Day, Year)			DLOURT	READ	RAN DAUST	OFFIN MA	RYLAND
	Stat Registra		MAR	32. Registra	rs Signature		1			

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09026 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Month Year MELTON IAMES 2.50 pm 2004 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) itomEW800 FUTURE CARE BALTIMONE BALTIMENE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Worth Day. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1/2 M 2□ F 8 | Yrs. NORTH CAROLINA 26 9987 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location BALTIMORE 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street end Number BENTLOW STREET Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 11. Marital Status 1 Never Merried 2 Married I DYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) ABORER 18. Mother's Name (First, Middle, Maiden 17. Fether's Name (First, Middle, Last) MELTON SR. 19b. Mailing Address (Street and Number or Rurel Route Number 1918 E. LAFNEHE WE. MELTON SISTER E. LATAYEHE 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State LEMOKIAC DARK 3.2404 BATIMITE MARKILAND 22. Name and Address of Fecility VAVOHIN C. GREENE FUNERAL HOME 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License BALTIMOLE, MARYLAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NOMENTIA Due to (or as a consequence of): ROSEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): ERTENSION Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HEART FATIURE CONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 2 Z No 1 ☐ Yes 2 ☐ No 1 Ves 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

28c. Injury at Work?

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

1 ☐ Yes 2 ☐ No

D0056948

BALTIMORE

28d. Describe how injury occurred

+1515 CM

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2004

MARCH 19

Ph, sician /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral Director

Completed by

**Funeral** 

Director

ò

6

al Hygiene.

if Health and Mental

Department of H Important: if ite eny injury or of

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Maryland 21215-0020

Baltimore,

Physician/Medical Examiner Be Completed by

Physician: The law requires thet the death certificete be executed Hospital or Attending

of Vital Records, P.O. Box 68760, Division

Medical Certification: To To the Hospital within 24 hours a To the Funeral Completely filled

31. Date filed (Month, Day, Year) State Registrar

JAMES

27. Manner of Death

1- Natural

2 Accident

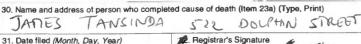
3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier



28e. Dete of Injury (Month, Day Year)

ENDING



28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

TANSINDA

5 Pending

investigation

6 Could not be determined

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH **Physician** MURIEL LAWRENCE 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Greater Baltimore Med. Center Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 □ F Yrs. N.Y. 37 11-10-66 Director 076-58-7285 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 le marked other then "natural", or items 23s or 28s-f ehow any injury or other traumatic event, the Medical Exercitment rount be notified at aging. 1√ Yes 2 No Director Md. Baltimore Cockeysville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 804 Cinnamonridge Dr. Apt. D 21030 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Specify: Black 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Clothing Store 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marvin Tate Carmen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Derod Omar Muriel Brother 5-I Meadowgrass Ct., Cockeysville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 💆 Burial 2 □ Cremation 3 □ Removal from State King Mem. Pk. 3-19-04 Randallstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 2120 1101 E. North Ave. 21202 Jebec March F.H. East Approximate Interval Between Onset and Death 216008 Part1. Enter the disease, or emplications that caus of the shock, or heart failure. List any one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final CARDIOVASCULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 TNo 24a Was an page 2 s certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA this : After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending To the news after death, within 24 hours after death.

To the Funeral Director: After the funeral in by the funeral management of the funeral 1 ☐ Yes 2 ☐ No ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number MARCH 18, 2004 ePut 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Lutherville Maryland 21093 Philip Militello, MD Trimble 6 32. Registrar's Signalure 31. Date filed (Month, Day, Year) State MAR 2 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month March 2004 1:50 p M **Physician** John Frank Miller /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll Lutheran Village If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Year) Sept. 26, 1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Mary Land 10 KM 20 F 84 Yrs. 217-01-3830 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State th and Mental Hygiene. 27 is marked other then "natural", or iteme 23a or 28a-f show traumatic event, the Macilcal Examiner must be notified at 1 Yes 2 No Upperco Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with U.S.A. 21155 15905 Trenton Rd. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes XXNo White Baltimore, Maryland 21215-0036 Y49672 1945 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Shop Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Luber John Miller ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15905 Trenton Rd. Upperco, Md. 21155 Mary Louise Miller - wife Health : permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr QDG. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State St. Pauls Church Cemi Marca 23,2004 Upperco, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Elles . Hill 21117 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 ☐Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has 1 Yes certificate s after death.

I Director: After this certifical of in by the funeral director, p. Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending 2 □ No 1 Tyes investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 - Homicide within 24 hours a
To the Funeral C filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hestminster m. PANSHRIYA 100 W 32. Registrar's Signature 31. Date liled (Month, Day, Year) State MAR 2 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200 is Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** llan March 2004 1032 PM Hinm /Medical 4c. County of Deeth 4e. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Himore Baltimore Medical Center C+) Mercy

5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
Florida 6. Sex **Funeral** Days Hours 1 DXM 2 □ F 30 223 90 4045 48 Nov Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State rthan "natural; or items 23a or 28e-f show the Medical Exagnitional be notified at 1 ☐ Yes 2 No Directo Baltimore Catonsville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6000 Edmonson Avenue 21228 United States Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 ☐XNo Specify. δ 3 Widowed 4 Divorced White Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene importent: if item 27 is marked other tha eny injury or other traumatic event, Lattone. Public Service Announcer Television 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Raymond Henry McClellan Nadvne Walls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy McClellan/Wife 6000 Edmonson Avenue Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriaf 2 XCremation 3 ☐ Removal from State Metro Crematory Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 3-22-2004 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Shem ( 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final yocardia **Physician** disease or condition resulting in death) /Medical Due to (of as a consequence of): **Examiner** lerosis Arteriose Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner iabetes use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No for 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 Junknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient Medical Certification: To 1 ☐ Yes 2 🗙 No 1 Inpatient 3□ DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident Injury 5 Pending 1 TYes investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, been signed by should be detact Division of Vital Records, page 2 certificate or Attanding Physician: ector. tuneral dir death.

nding physician

death with the Maryland

Baltimore, Maryland 21215-0036

29a. Certifier

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

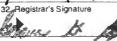
30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Katherine M. Prybys 3ol St. Tau

31. Date filed (15-25)

Street Beltimore

State Registrar 31. Date filed (Month, Day, Year) MAR 2 2 2004



1941

			For State Registrar	State of Marylan		irtment of H			ene 200	09031
	74.4	gr .	Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia	an	41	ZEULLO				MARCH	Day Year	A LE DM
	_/Medic		4a. Facility Name (If not institution, give str			4b. City. Town, or	Location of Death	MARCH	4c. County of De	
	Examin	er	11 f Ma	Men Men	calla.	La Roll	1	( tu		
			5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign
	Funeral Director			M 2X F 91	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, ) Jan. 27, 1	913 Nei	Country)
			Usual Residence of Decedent					,		
land	Mo m		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Mary	d di	to	MD Howard	C	olumbia	а				Y☐Yes 2☐No
the the	28a	ec .	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	Country?
į	3a of	0	7080 Cradlerock Way	1 #309		21045			USA	
Teat	TIS 2	Funeral Director		2. Was Decedent Ever in U	.S. 13. V	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
flar	an and	F	1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1	r Yes, specify Cuba 1 □ Yes 2 No	Specify:	nicari, etc.)	Black, Wh	
U K I K I 3-0000	*natural", or itams 23a or 28a-f show edical Examiner must be nicilified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	зреспу.		Specify: (	Vhite
5 2	real	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced	ient's Usual Occup	ation during most of work	ina 16	3b. Kind of Busines	s/Industry
F id	- Pag	ρig	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work			
<b>1</b> 5	gien T	NO.	12 0		Supe	rvisor			Departme	<u>it Store</u>
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should be	rked ilc e	2	Carmine Mezzullo				Maria Ce	rasliolo		
2 4	and )		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Route Number, (	City or Town, State,	Zip Code)
, TA	127 E		Michael Genovese /	Nephew					Maryland	
- ע	of Head f Item r other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispo cemetery, cren	sition (Name of natory or other place		Date 20	Oc. Location - City of	r Town, State
	Department of Important: If II any injury or one		1 □ Burial 2/C□Cremation 3 □ He 1 □ Donation 5 □ Other (Specify)	Bal	t/Wash	Cremator	1/3 = 3/18	/2004	Laurel, M	<i>laryland</i>
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ă	Depar Impor any in		* Ostophomio (	100 moi	220	7601 Sano	ly Spring	Road, La	urel, Ma	iyland 20707
w			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea	th. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
٠ ,	husisian		Immediate Cause (Final		/	2 Accia	10.t			Onset and Death
	hysician /Medical		disease or condition resulting in death)	Due to (or as a consec	-	Z MCCIO	CENT			6 hours
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ַ מֿ	e atten	cia	in the past 12 months?	4☐ Pregnant at time of o		Other (specify)			Month	Day Year
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ō	or this oral di	15-	27. Manper of Death	28a. Date o Injury	28b. Time o			28d. Describe how		,
5	h. After funer	ţ.	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury		Yes 2 □No			
Division	death. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, str	reet, factory, office				Rural Route Number,
É.	after Dire	Certification;	4 Homicide	building, etc. (Speci	ny)			City or Town,	State)	
:	to the hospitel or Attending Friystoan.  To the Funeral Director: After this certifica completely filled in by the funeral director.			ician: To the best of my kn						
:	P Fu	edical	(Check only & Medical Examin	er: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	ppinion, death occur	red at the time, dat	e and place, and d	ue to the cause(s)
:	Withir To th	Me	29b. Signature and title of certifier	//		29c. Licens	se number	296	d. Date signed (Mo	nth, Day, Year)
ď			1.1/11/	( (a)		717	1726	n	Marcil 17	2004
	IV		30. Name and address of person who gor	mpleted cause of death (Ite	m 23a) (Type.	Print)	ſ.	/ , ;	101	1 21
	4		Timothy N. M96	Usughein DC	, UNIO	resily o	+ Mxu 6	us Medica	/ Certer &	sittemond of
	St	ate	31. Date filed (Month, Day, Year)	Registrar's Sign	ature					7
	Regist	trar	MAR 2 2 2004	A STATE OF A	A STAN	122				

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Amend Item 1 per Dr. G830,04/13/04dhb

For Amend Item#11, per Informant, G830, 4/7/2004, gap

State RegistrerAMEND ITEM#1 PER PHY G830 4/07/04 JICertificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) NORMA MAY NOAH Day Year Month **Physician** NORMA MAE NOAH Norma May Noah March 20 2004 11:12 p /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y Nov. 29, Birthplace (State or Foreign Country)
 MaryLand 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F 58 Yrs. 220-46-6344 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Carroll Finksburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21048 2751 Cold Saturday Drive U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 9002e. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Howard Allen, Sr. Mary Lookingbill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Noah - husband 2751 Cold Saturday Dr., Finksburg, Md. 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Trinity U.C.C. Cem. March 23,2004 Manchester, Md. ' 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

Echhardt Fineral Chapel F. A.

11605 Reisterstown Rd. Owings Mills Md. 2771/
Approximate Interval Between Onset and Death 21. Signature of Funeral Service Licensee 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER UNG ears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 4 Pregnant at time of death ed by the a 9 Unknown 9 Unknown cate has been signed page 2 should be det Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☑ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funerel Dire completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1225205 MArdy 21, 200x

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State Registrar 31. Date filed (Month, Day, Year) MAR 2 2 2004 32. Registrar's Signature

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N. Charles St.

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Registrar

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Patricia P. Protani Maryland 21215-0036

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	ns 2;	Funeral Director	· · · · · · · · · · · · · · · · · · ·		J.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	city Yes or N	0- 14.	Race - America	
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygene. If marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Maryland Examinations to notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	<ul> <li>12. Was Decedent Ever in United Forces?</li> <li>1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:</li> </ul>		1 ☐ Yes 2 ☐ No	Specify:	rican, etc.)		<sup>Black, White, e</sup>	
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	vithin Fo the	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date si	gned (Month, D	lay, Year)
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	1/		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type	o, Print)	ien Blva	Bal-	tim		
0	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 2 2 200	32 Pegistrar's Sign	nature	LUN NAV	DIVU	10-11		L, 141	-160
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State of Maryland / Department of Health and Mental Hygiene? [] [] [] 09036 1 - For State Registral Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name, (First, Middle, Last) Morevch rettawa\ Physician /Medical 4a Facility Name (If not institution, give street and number) City, Town, or Location of Death Baltimore 4c. County of Death Examiner NIH If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 27, Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Year **Funeral** Months Days Hours 1 **№** 2 🗆 F 37 Yrs. MD 1966 218-98-3609 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location or itema 23e or 28e-f ahov permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other then "natural; or Items 23e or 28e-1 show any injury or other treumatic event, the Medical Exercises must be notified at 1KYes 2 No Directo MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 United States 150 North Denison Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **Z**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hospital Elementary/Secondary (0-12) College (1-4or 5+) Laborer 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Jackson Brenadine Pettaway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 150 North Denison Street, Baltimore, MD 21229 Mrs. Sheila Gray-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Mar 26 1 Removal from State 2004 Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Mount Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Calvin L. Williams Funeral Home, P.A. win L. MD 2818 East Baltimore Street Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No certificate Division of Vital To the Hospital or Attanding Physicien: : After this certification, 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Unpatient 2 ER/Outpatient 3□ DOA 1 🗌 Yes Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by 4 - Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1217643 HAR 19,2004 MD 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIHOR MI South hreent F-E TSA T. 32. Registrar's Signature 31. Date filed (Month Day, Year) State Registrar

		4	- State Amend Item #	State of Ma 9, per <u>FH</u> , G829,	aryland 3/22/20	7 Depa 004 <del>Cen</del> l	rtment of H Rificate of L	ealth and M D <i>eath</i>	ientai Hy	giene 2	2004	09037
ı			1. Decedent's Name (First, Middle						2. Date of De Month		Year	3. Time of Death
	Physicia /Medic	_	DEBRA	RANDAL	L_				3	9	04	9:00 R.M
	Examin	er	4a. Facility Name (If not institution 628 N. Eutaw P.	•	3		4b. City, Town, or Balto	Location of Death			unty of Deeth	
	Funeral		5. Social Security Number		(In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bil	rth ey_Year)_	9. Birth	place (Stete or Foreign intry)
	Director		216-52-3016	1□ M 2√EXF	53	Yrs.			8-19	-1950	MD	<del>Me</del>
	and *	}	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits
	Maryli f eho	ō	Md	N/A	Ba	lto						1 Yes 2 □ No
	the 1	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizer	of What Cou	intry?
	h with	D E	628 N. Eutaw I	Place Apt 50	3		212	01			USA	
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?		. 13. V	Vas Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)		Race - Amer Black, White	
20	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Ie marked other than "naturelt, or Iteme 23s or 28s-t show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Mamed 2 ☐ Marr 3 ☐ Widowed 4 💆 Divorced	ied 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No		□Yes 2∏ No	Specify:				Black
200	2 hou	ted	15. Deceden	's Education		16a. Deced	lent's Usual Occupa	ation during most of work	ina	16b. Kind	of Business/Ir	ndustry
2	en "n	Completed	(Specify only highes Elementary/Secondary (0-12) 12th grade	Collège (1-4or 5	i+)	life. L	OO NOT use retired	)	n ig	Ba1	timore	Times
7	e filed within al Hygiene. I other then "	Co		College		Kec	eptionis		- (First Adidal)	Maidan Su		
yiand	be fill H of other	Be	17. Father's Name (First, Middle, James Edward Ra					18. Mother's Name				
_	2 should be f and Mental I le marked of reumatic eve	ို	19a. Informant's Name/Relations			19h Mailin	n Address (Street	and Number or Rur				in Code)
Z	d 2 sl th an th an treur		Carl Randall -					e Avenue				21215
อ์	Health tem 27 tem 27		20a. Method of Disposition		20b. Pla	ce of Dispos	sition (Name of natory or other place	1	Date		tion - City or T	
Baitimor	Pages nent of ant: If I		1 Denial 2 ☐ Cremation 14 ☐ Pontation 5 ☐ Other (S		Arbi	utus M	lemorial	Pk  3-15-	2004	Arb	utus,	Md
gall	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other ance.		21. Signature of Funeral Service	Licensee	0	22	. Name and Addres	P.	larch F			Md 21215
- de la	\$		23a. Part 1 Enter the disease, or shock or heart failule. List	complications that caused	the death.	Do not ente					Darco,	Approximate Interval Between
	Physician		Immediate Cause (Final					- DIST				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as			PCIONE	- 0(3)	21126	,		
	Examiner		Sequentially list conditions	AIDS	5							
7	ק ב	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):						
	and -trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ance of):						
8/60,	eath certificate be executed attending physician and for use as the burial-transit	aiE				.,,,						
2	ficate p phys is the	edicai		d								
ROX	nding use a	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy			230	d. Date of deliv	
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒No	4☐ Pregnant at			Other (specify)				Month	Day Year
٦ ٥	at the de	Phy	9 Unknown		ut not recul	tion in the	ndashina anuna anu	on in Dort I	23e Did	tobacco use	contribute to	tha cause of death?
ds,	The law requires that the death certif ite has been signed by the attending page 2 should be detached for use a	by	Part II. Other significent condition	ons contributing to death b	ut not resul	ung in the ur	nderlying cause giv	en in Pait i.				bably 4 Dunknown
Ö	w require been signal	iete		-					24a. Wa:		24b. Were aut	lopsy findings available
Ϋ́ E	rsician: The law s certificate has I lirector, page 2 s	Completed							рел	opsy formed? 22 No	death?	ompletion of cause of 2 No
Ta		BeC	25. Was case referred to medica					26. Place of Deal				-7
<u>&gt;</u>	nysici IIS COI direc	To B	examiner? 1 ☐ Yes 2 ◯ No	Hospital: 1 ☐ Inpati	ent 2 🗆 E	R/Outpatien	nt 3□ DOA Oth	er: 4 Nursing Ho	ome 5 Res	idence 6	]Other (Spec	elfy)
0	ding Phy h. After thi funeral o		27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date of Inju (Month, Da	y Yeer)	28b. Time of Injury	Wor		28d. Describe	how injury o	occurred	
200	tending to the total	cati	2 Accident investi	gation				Yes 2 No	006 Lasation	(Ctoopt and b	(umbas as Du	m I Davida Mumba
Division of Vital Records,	after death.  Director: After this certific in by the funeral director.	Certification:	4 Homicide determ	nined 289. Place of In	ic. (Specify)		eet, factory, office		City or To	own, State)	vumber or Au	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical C		ng Physician: To the best Examiner: On the basis of and manner st	f examinati							
	Fo the	Me	29b. Signature and title of certifie				29c. Licens	e number		29d. Date s	signed (Month	n, Dey, Year)
	- > - 0		Mark	DOLA			DO	057166	2	3/1	0/64	
	2		30. Name and address of person	who completed cause of	death (Item	23a) (Type,						
	رسر		1830 E. MON	nument 5	ot, I	Balt	more	, MD	2129	8,1		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year, MAR	32. Regist	gr's Signati	ure /	Souli !	1				

Please Type of Frint in Black indelible link. Elisure All Copie	es Are Legible.	
State of Maryland / Department of Health and Mental H	lygiene o	
State of Maryland / Department of Health and Mental F  Certificate of Death	Beg. No. 2004	09038

LARRY	LESTER	R 1	ROBINSON	State of Ma	arvland / D	epartment of I	Health and M	Mental Hv	aiene.		
		•	For State		-	Certificate of			Reg. No.	2004	09038
			Registrar  1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath		3. Time of Death
	Physicia	n i			aon			Month MARCH	21,	2004°	0657 A M
	/Medic:		Larry Lester  4a. Facility Name (If not institution, give		5011	4b. City. Town.	or Location of Death	4		ounty of Death	
	Examine	er	34 GLENWOOD ROAD			ESSE				ALTIMOR	E
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birth			8. Date of Bir	th	9. Birthp	lace (State or Foreign
	Director		213-62-5898	MOM 2□F	49 Y	rs. Months Days	Hours Min.	8/19/	1954	West	Wirginia
	D	Ì	Usual Residence of Decedent								
	trylar thow		10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits 1 ☐ Yes 2X No
	8a-1.	cto	Maryland Baltimo	re	Essex						
	72 hours after deeth with the Maryland naturs!, or Itsme 23a or 28a-f show dical Exscrimer must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cour	itry?
	9th w		34 Glenwood Road	Apt "C"		21221				S. A.	
	ar de	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?		<ol> <li>Was Decedent of If Yes, specify Cub</li> </ol>	Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14	Black, White,	
36	or i		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:	lo .	1 ☐ Yes 🎾 No	Specify:		s	pecify:	
Ş	turs!	Completed by	15. Decedent's E		16a l	Decedent's Usual Occu	pation		16b Kind	Whi	
<del>7,</del>	in 72	jet	(Specify only highest gr	ade completed)		Give kind of work done life. DO NOT use retire	during most of world)	king	100.11	01 2001100011	-0011 y
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d 2	Hygid Hygid Sthar		17. Father's Name (First, Middle, Last	)		BOLCI	18. Mother's Nam	ne (First, Middle			
an	d be ental ked o	To Be	Lester Robin	son			Dolores	May	7	Umstot	
Z.	ges 1 and 2 should be filed within 72 hours after deeth with the Marylan it of Health and Mental Hygiene it of Health and Mental Hygiene it or its marked other than "natural", or itsme 23a or 28a-1 show or other traumatic event, the Medical Exeminer must be notified at	-	19a. Informant's Name/Relationship		19b.	Mailing Address (Stree					Code)
ž	and 2 salth a n 27 ls	I	Lester Robinson	(Father)	14	13 Hopewel	l Avenue	Essex.	Marv]	Land 212	221
ē,	f Hez f Hez ttsm othe		20a. Method of Disposition			Disposition (Name of , crematory or other pla		Date		ition - City or To	
ě	Pages nent of i int: If its iry or o		1 Burial 2 TCremation 3 C 1 Donation 5 Other (Speci	☐Removal from State  fy)		w Crematory	3/2		Balti	more N	Maryland
	그 문원를 다	ı	21. Signature of Funeral Service Lice		Trayvic	22. Name and Addre	ess of Facility	2 "		inole, i	LL / Lana
ä	Depermine Depermine Important in seny irrespondent		Michael C 5	1/2 50		Bruzdzinsl				Marvla	nd 21221
165			23a. Pert1. Enter the disea or conshock, or heart failure. List only	ations hat caused	the death. Do no						Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence o	condusa	solder e	li se a co	?		
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	cuted	Examiner	that initiated events	c.							
ó			resulting in death) Last	Due to (or as	a consequence o	l):					
8760,	cate be exphysicien the buria	cal		d			-				
39	leath certifica attending ph I for use as th	Physician/Medicai	IF FEMALE:							1	
Вох	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal death	3 ☐Ectopic pregnand	y		23	<li>d. Date of delive Month</li>	ry Day Year
9.	the a	Sici	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of death	5 Other (specify)					,
P.O.	that the de ed by the detached	F.	Part II. Other significant conditions	eastablished to death by	ut not requiting in	the underhing enume	una ia Dort I	22a Did t	chacca use	contributo to th	ne cause of death?
Ś	res that signed be be det	þ	C la serve s	chember of a s	at not resulting in	the underlying cause gr	veri in Fait i.	1)27	_		ably 4 □Unknown
or o	w requir been si should	ted	Christian	,	J. Ch	vorue_					
ec	ne law has b je 2 sł	Completed	obstructive pu	Imonary o	lisease	-		24a. Was autor	osv	prior to cor	psy findings available apletion of cause of
<u>=</u>		Co						i)≱Yes	rmed? 2 ☐ No	death?	2 No
¥ ta		Be	25. Was case referred to medical examiner?	Hasaital:			26. Place of Dea	3			
of	N S D	၉	1X Yes 2 No		nt 2 ER/Out	Dation: 3 DOA		ome 5 Resi			AT SCENE
<u>_</u>	ding F	on:	27. Manner of Death  Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b. Ti	jury Wo	rk?	28d. Describe	now injury o	occurred	
<u>s</u> .	Attending r death. sctor: After oy the fune	cat	2 Accident investigation 3 Suicide 6 Could not I		.m. At hama for		]Yes 2□No	206 Location /	Ctrant and	Number of Over	I Claude Alumba
	or Al	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	m, street, factory, office		City or To	wn, State)	vuiliber or Hura	l Route Number,
9	Hospitel or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 ☐ Certifying P	hysician: To the hest	of my knowledge	death occurred at the ti	ma, date and place	and due to the	C31160/6) 31	nd manner as st	ated
	To the Hospitel or Attending Physical 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Medical			examination and	or investigation, in my					
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date :	signed (Month,	Day, Year)
	->-0		Fourther &	raelse	mo	0.	C.M.E		MA	RCH 21	, 2004
			30. Name and address of person who	completed cause of d	eath (Item 23a) (	Type, Print)					
	V		Tasha Z Green		111 P	enn Street,	Baltimor	e. Mary	land	21201	
				/ 1							

31. Date filed (Month, Day, Year) State Registrar

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

			1 - State Amend Item Registrar		h''G829''	3/26°0 Ce	t tas rtificate of	Death	2. Date of De		
	Physicia	an	1. Decedent's Name (First, Middle, Robert Lawrence	_					Month	Day 2004	3:35 P M
	/Medic	4.	4a. Facility Name (If not institution,		mber)		4b. City. Town.	or Location of Death		4c. County of Deal	
	Examin	er	Greater Baltimo			er	Towson			Pol+imo	<b>14</b> 0
2.7	Funeral			S. Sex	7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Bir	th6/18/1926Bir	thplace (State or Foreign ountry)
u .	Director		212 20 9262	1XM 2□F	75	Yrs.	Months Days	Hours Mill.	June 18	7, 1928 · Mi	chigan
	p >		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	anyla sho	50	Maryland Baltim	ore		Ruxt					1 ☐ Yes 2 X No
	the N	Director	10e. Street and Number			1(021)	10f. Zip Code			10g. Citizen of What Co	ountry?
+	3a or		1800 Roland Aver	nue			2120	)4		USA	
2	death with the Maryland ims 23a or 28a-f show imst be notified at	Funerai	11. Marital Status		edent Ever in U	.S. 13.	Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No		
وي	after or Ita	/ Fu	1 ☐ Never Married 2 ☐ Marrie		2 🗌 No		1 ☐ Yes 2 ☑ No		r riouri, etc.)	Specify: Wh	
20\chi2	ural',	d by	3 ☑ Widowed 4 □ Divorced	Year or D	ates:	11					
Z 12	within 72 hours ane. than "natural", the Madical Ext	iete	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	aduring most of work	king	16b. Kind of Business	Industry
2121	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1	1-4or 5+)		Banker			Banking	
	illed Hygi other	Be C	17. Father's Name (First, Middle, L.	ast)				18. Mother's Nam	e (First, Middle	, Maiden Surname)	
land	Mental Arked o	To B	John J. Stipsak					Elizabet	h M. Ja	ntosky	
ary C	2 short and his ma		19a. Informant's Name/Relationshi							er, City or Town, State,	Zip Code)
Z.	1 and 2 Health tam 27		Marlene P.Wise	(Sister)				d. Baltimo	ALC: NO PERSON NAMED IN COLUMN		
Baltimore	Pages 1 nent of H int: if itar iry or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3	B □Removal from	State	cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location - City or	
A TE	. Pag tment tant:		*4 □Donation 5 □Other (Special		Ma.			son 3/24/	2004	Garrison For	rest, Md.
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or othar traumatic event. The Medical Exeminer must be notified at once.		21. Sign Ture of Funeral Service U	Sensee	a ba		2. Name and Addr Bruzdzins		1 Home	P.A. ssex, Md. Z	W 204
100	TE 8 E 0 E		23a. Part 1. Enter the disease, or cash ck, or heart failure. List o	omplications that of	caused the deal	th. Do not en	ter the mode of dy	Fastern A	or respiratory a	issex, Ma. Z	Approximate
			shr ck, or heart failure. List o Immediate Cause (Final	nly one cause on	1	4. 4	764				Interval Between Onset and Death
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	Examiner				ement	A	try ?	Siscins			
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9 ×	leath certificat attending phy I for use as th	/Me	IF FEMALE:	23c. If yes, ou	tcome of pregn	ancy				23d. Date of de	livery
Вох	leath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregr	ointh 2 ☐ Feta nant at time of o		□Ectopic pregnand □ Other (specify) _	cy		Month	Day Year
P.O.	that the death ed by the atte detached for	hysi	9 Unknown	9□ Unkn	own						
ر. ح		by Physician/Med	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	inderlying cause g	iven in Part I.	23e. Did	tobacco use contribute to	the cause of death?
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Division of Vital Records,	law re as be	Completed							24a. Was	psy prior to	utopsy findings available completion of cause of
= H	The Late has	Соп							perfo 1 ☐ Yes	ormed?// death?	
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:			10	26. Place of Dea			
of	tending Physician: leath. tor: After this certific the funeral director,	٠ <u>۲</u>	1 Yes 2 No	10	of Injury	ER/Outpatie	III JU DOA			idence 6 Other (Spe how injury occurred	cify)
u o	ding h. After funer	tion	1' Natural 5 Pending 2 Accident investiga		of Injury hth, Day Year)	Injury	W	ork? □Yes 2□No	200. 20001100	now injury occurred	
İsi	al or Attendir s after death. Il Diractor: Af d in by the fu	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place	of Injury - At h	ome, farm, st	reet, factory, office	)		Street and Number or Ri	ural Route Number,
á	al or s after ii Dire	Certification:	4  Homicide	Dillia	ing, etc. (Speci	<i>(y)</i>			City or To	wn, State)	
1/4	Hospita 4 hours Funera tely fille	Medical		xaminer: On the b						cause(s) and manner as date and place, and due	
9	To re in 2 To the complei	Mec	29b. Signature and title of certifier	and mail	stated.		29c. Licer	ise number		29d. Date signed (Mont	h, Day, Year)
	2 1 8			27	Army	0	Do	005876	1	3/20/20	204
	A		30. Ne e and ddress of person w	no completed cau	se of death (Ite	m 23a) (Typ	, Print)		,	MD 313	
_	D.		Michael 3	y my	67	1-10	Vichil	0 St To	No.	NO 319	24
1	Sta Regist		31. Date filed (Month, Day, Year)	Ed.	Registrar's Sign	ature	and s				

			For State Registrar	State	of Maryla		artment rtificate			nd M		giene Reg. No.	2004	09040
	Physici /Medio Examir	al	Dorothy     Aa. Facility Name (If not institution,		L.	Sin	ngleto 4b. City, T	own, or		f Death	2. Date of De Month 3	12 Day	2004 County of Deeth	3. Time of Death 1:30p M
40	Funeral Director		218-76-9131	e Ave. 6. Sex 1 M 2X F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1		If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth	* *
	death with the Maryland ma 23a or 28a-f show must be rediffed at	ector	Usuel Residence of Decedent  10a. State  Md.  NA	1	10c. C	Balti	more							10d. Inside City Limits 1X Yes 2 ☐ No
		Funeral Director	10e. Street and Number 5708 Beachdale 11. Marital Status	12. Was Dec			10f. Zip C 212 Was Decede If Yes, specif	.39 Int of His	spanic Orig	in? (Spe Puerto F	cify Yes or No		USA  4. Race - Ameri Black, White,	can Indian,
212-0036	filed within 72 hours after Hygiene. ther than "natural", or Ite int, the Medical Examine	Completed by F	1 Never Married 2 Marrie 3 Widowed 4 XDivorced  15. Decedent (Specify only highes)	s Education grade completed,		16a. Dece	1 ☐ Yes 2/ X dent's Usual kind of work DO NOT use	Occupa done d	urina most	of workin	ng		Specify: B.	lack
V	be filed ital Hyg od othe	Be	Elementary/Secondary (0·12)  12th grade  17. Father's Name (First, Middle, L.  William		1-4or 5+)		sekeep	oing	18. Mother	's Name nda	(First, Middle,	Maiden .	ies Sumame) Young	
Maryiand	s 1 and 2 should by Health and Menta item 27 is merked other traumatic en	2	19a. Informant's Name/Relationsh Mildred Williams		ster	19b. Mailir			nd Number	or Rural		er, City or	Town, State, Zip	Code)
saitimore,	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition  1 ∑Burial 2 □ Cremation  1 □ Donation 5 □ Other (Sp	3 □Removal from	20b. State	Place of Dispo cemetery, crea	natory or oth	er place	. )	3–18	-04		cation - City or To	
Bait	permit. Pages Department of PImportant: If its eny injury or of Once.		21. Signature of Suneral Service L			22	Name and	Address	s of Facility	В	altimo	ce, M		
	Physician /Medical		23a. Part. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Chi	caused the dea	age C					respiratory a			Approximate Interval Between Onset and Death
08/00,	ate be executed hysicien and the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. J	(or as a conse	Type	II c		nt	he	Tove			
O. BOX 68	death certific e attending p od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	tcome of pregribinth 2 Fet prant at time of lown	el death 3	Ectopic pred					2	3d. Date of delive	ery Day Year
cords, P.	w requires that the de: been signed by the a should be detached f	by	Part II. Other significant condition	as contributing to o	leath but not re	sulting in the u	nderlying cau	ise give	n in Part I.			_	_	ne cause of death?
Ž	The law ate has b page 2 s	Completed	25. Was case referred to medical	• • • • • • • • • • • • • • • • • • • •							1 ☐ Yes	rmed? 2 No	24b. Were auto prior to co- death? 1 \( \sum \text{Yes} \)	psy findings available inpletion of cause of
r Vital		To Be	examiner?	Hospital:	Inpatient 2	] ER/Outpatien	it 3 DOA	Othe			(Check only o		Other (Specify	
DIVISION OF	D 0 0	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation	of Injury ith, Day Year)	28b. Time of Injury	М		at ? es 2 □ N	0	8d. Describe f			
2			4 Homicide determin	ned 28e. Plac	of Injury - At h						City or Tov	vn, State)		l Route Number,
	the Hospitel ( hin 24 hours al the Funeral D npletely filled i	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To th xaminer: On the b and mar	e best of my kn pasis of examin iner stated.	iowledge, death ation and/or in	occurred at vestigation, in	the time n my opi	e, date and nion, death	piace, ai occurre	nd due to the d d at the time,	cause(s) a date and p	and manner as si place, and due to	ated. the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	> /-				License		0 5			signed (Month,	
	Δ		and address of person v	. 1	se death (Ite	om 23a) ype,	Print)	XX	257	E 3.	5	2.1	1-01	4 D Q1239
	Sta Registr	- 1	31. Date filed (Month, Day, Year) MAR 2 2 2004	32.1	Registrar's Sign	die Sy	sorks	- K	uver	1 (0)	000		CTO. MY	J W1257

State of Maryland / Department of Health and Mental Hygiene 2004 09041 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 18, 2004 MONTH **Physician** JAMES SALMOND WOODRUFF 12:45P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility. Name (If not institution, give street and number) Examiner Center OWSON Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**XM 2□ F 135-24-8964 72 04-09-1931 Director NEW JERSEY Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2√√No Director MD. LUTHERVILLE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number WIT ö 128 RIDGEFIELD ROAD 21093 U. S. A. Items 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black White etc Armed Forces? XXYes 2□No1952-If Yes, Give Year or Dates: 1953 Pages 1 and 2 should be filed within 72 hours after 1 Never Married XX Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes XX No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other then "natu 16b. Kind of Business/Industry College (1-4or 5+) YEARS Elementary/Secondary (0-12) ELECTRICAL ENGINEER ENGINEER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I ARCHIBALD SALMOND URSULA CROWELL 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) A. SALMOND item 27 l DORIS (WIFE) 128 RIDGEFIELD ROAD, LUTHERVILLE, MARYLAND, 21093 20a. Method of Disposition

1 Burial 2XXCremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete permit. Pages I Department of H Important: If ite any injury or ot once. TOWSON, MARYLAND, 21204 HILLTOP SERVICE CORP. 03-22-2004 A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD R. H. Ruth RUCK TOWSON FUNERAL HOME INC., TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE CARDIOMYOFATHY **Physician** YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RECURRENT CARDIAC ARRHYTHMIAS 1 MONTH Security 1st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year Por in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.0. detached 9 Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, End Stage Renal Diseae 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Severe peripheral vascular disease 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 140 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter 1 Natural 2 Accident Iniury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation in by the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 T Homicide within 24 hours a To the Funeral C Pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 19,2004 elou, M. D17695 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

MAR 2 2 2004

31. Date filed (Month, Day, Year)

ABDALLAH JOSEPH HELOU, M.D.,

32. Registrar's Signature

7601 OSLER DRIVE TOWSON MARYLAND 21204

State of Maryland / Department of Health and Mental Hygiene 2001 State Registrar AMEND ITEM #7&8 PER FH G829 3/22/04Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 16 2004 4:13 ам Frank R. Smith /Medical 4a. Facility Name (If not institution, give street and number)
Buchinghams Choice 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Adamstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth4—22—1919 9. Birthplace (State or Foreign Months Days Hours Min. (Months Day Year) Dunes, PA 5. Social Security Number **Funeral** 1 M 2 □ F 178-10-8942 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Itame 23a or 28e-f show other treumatic event, that Medical Examinar must be notified at 1 Yes 2 No MD Barnsv Director Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 30838 21610 12. Was Decedent Ever in U.S. Armed Forces? 1 Des 2 U No Nay If Yes, Give Year or Dates: , q 43-1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) IBS Gavernment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other treumatic event Vernon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burnsulla MD 20 20c. Location - City or Town, State Smith 20838 21610 Ballsville 9 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metro 3/25/04 rematery 21. Signature of Funeral Service License 22. Name and Address f Facility 1232 Mid-Valley Dr. Jessup lent Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** un /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 2 12 No 3 Probably 4 Unknown cate has been signated by page 2 should b 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No of Vital Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred **Division** 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and Iller of certifier care 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seiker MO 432. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2000 In

		ľ	1 - For State Registrar	State of Maryla		artment rtificate				Reg. No		
I	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of Month March	Da	y Year 2004	3. Time of Death 8:05 a. M
	/Medic Examin		Charles Walter Sm  4a. Facility Name (If not institution, give s			4b. City, T	own, or l	ocation of			. County of Deet	
	LAGITITI	CI	Johns Hopkins Bay	view Medica:	l Center	Bal	timo	re			N/A	
	Funeral Director	-5	410-36-7120	7. Age (In your Age)	rs. last birthday) Yrs.	If Under 1 Months	Days Days	If Under 24 Hours	Min. 8. Date of (Month, OCt.	Day, Year,	Co	thplece (State or Foreign buntry) INESSEE
	land land		Usuel Residence of Decedent  10a, State  10b. County	10c.	City, Town or Lo	ocation						10d. Inside City Limits
	Mary B-f sh	tor	Maryland Baltimo	ore I	Dundalk							1 ☐ Yes Ž ☐ No
	or 28	Dire	10e. Street and Number			10f. Zip (	Code			10g. C	itizen of What Co	ountry?
	s 23s	erai	2601 Gray Manor T	errace 12. Was Decedent Ever in	118 13		1222		n? (Specify Ves or		ited Sta	
39	urs after de si', or Itam xaminer	by Funeral Director	11. Marital Status  1 Never Married 27 Married  3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No		If Yes, specif		Specify:	n? (Specify Yes or Puerto Rican, etc.)		Black, White	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be nullined at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use	done du	ion iring most o	of working	16b. F	Kind of Business/	Industry
2	fygien tygien her th nt, the		11 years 17. Father's Name (First, Middle, Last)		Mech	nanic		19 Mother	s Name (First, Mide		Automoti	ve
and	d be fi	o Be							Mae Worms		1 Juliane)	
Maryland	shoul nd Me mark	70	Clarence B. Smidd  19a. Informant's Name/Relationship (Ty)		19b. Mailii	ng Address (			or Rural Route Nui		or Town, State, 2	Zip Code)
	is 1 and 2 of Health a item 27 is other trau		Edith Ann Smiddy			-		or Te		ndal	k, Maryl	and 21222
Baltimore,	ges 1 of He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	I .	cemetery, crei	osition (Name matory or oth	e of her place,	)	Date	20c. L	ocation - City or	Town, State
Ħ.	t. Pag rtmenl rtant: njury		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Furieral Service License						/20/2004		ndalk, M	
Ba	Depa Impo any is		Assedon	E Keen					l Home of Dundalk		dalk, In ryland 2	
	Physician /Medical		23a. Part1. Enter the disease, or comblishock, or heart failure. List only or Immediate Cause (Fixed disease or condition resulting in death)	Due to (or as a cons	CAN	CEI	<u>K</u>		:-32	y arrest,		Approximate Interval Between Onset and Death
	Examiner political	Examiner	Sequentially list conditions, hary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	PXIER	ES STEC	SIN	LLS	75	5."			
8760,	cate be executed physician and the burial-transit		resulting in death) Last	byte to (or as a cons	sequence of):	8 P.I	LLA	TO	4			
.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of predictions of the control o	etal death 3	⊒Ectopic pre ⊒ Other (spe				-	23d. Date of deli Month	ivery Day Year
rds, P	es De g	þ	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	inderlying ca	use giver	n in Part I.		id tobacco □ Yes 2	_	the cause of death?
Vital Records,	The law ate has b page 2 s	Completed								itopsy rformed?	prior to death?	utopsy findings available completion of cause of
/ita	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	lospital:		/			f Death (Check on	ly one)		
of	문 = 표	- To	1 Yes 2 No	1 ☐ Inpatient 2 28a. Date of Injury	28b. Time o	-	Other	4   Nurs	ing Home 5 ☐ R			cify)
on	Attending r death. ector: After by the fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year,	) Injury	М	Work?	5`` es 2.∐No			.,,	
Division	o i i i	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe		reet, factory,	office			n (Street ai Town, Stat		ıral Route Number,
	Hospital	dical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred a vestigation, i	t the time in my opi	e, date and nion, death	place, and due to t occurred at the tim	he cause(s ne, date an	and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c.	License	number	etica	29d. Da	ate signed (Month	h, Day, Year)
	- > - 0		Doduhoo	( Stella	198	1	2	27/2	58	-	3/96	le l
	4		30 Name and address of person who co	empleted cause of death (I	tem 23a) (Type,	Print)	A	1 2	/ x	-	10-	x 1-222
	- 0.		St. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature /4	all	W!	( (0	uce V	MA	AVIC M	D 4322
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HOWRIETTY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No.2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 03 **Physician** 0205AN 04 Henrietta C. Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Levindale N/H N/A Balto If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F Yrs. Director 7-18-1928 Md 216-20-6369 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County itam 27 is marked other than "natural", or itams 23a or 28a-1 show other traumatic event, the Nedicul Examinar must be notified at 1 Yes 2 No Balto Randallstown Md Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA 5107 01d Court Road 21133 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3√ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d 2 should be filed withIn 72 th and Mental Hygiene. 7 Is marked othar than "na Deputy of Wills College (1-4or 5+) Elementary/Secondary (0-12) N/A Assistant Registrar 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eddie Murray Eleanor Irby 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Legartment of Health an Important: If itam 27 is many injury or other Danyell T. Williams - Cousin 11538 Waesche Drive Mitchellville, Md 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 3-22-2004 Balto Co, Md Woodlawn Cemetery 21. Signatule of Funeral Service License 22. Name and Address of Facility March F/H 4300 Wabash Avenue Balto, Md 21215 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure in the only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): attending physicien Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HTN Completed CAD 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy DM 2 No Division of Vital Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No this 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending efter death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours e Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 056508 MO XIANGRENG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore ave Wedere 32 Aegistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MAR 2 2 2004

Dhamis		1. Decedent's Name (First, Middle, La	ast)			artment of H 2004, gap rtificate of L			ate of Death	n Day	Yeer	3. Time of Death
Physici /Medio				Gracie	E.	Thomas				cy 18		8:16p.
Examir		4a. Fecility Name (If not institution, give		mber)		4b. City, Town, or	Location of	Death		4c. Coun	ty of Death	
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Funeral		5. Social Security Number 6. S	Sex 1□M 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours 24	Min. (A	ate of Birth fonth, Day,		Cour	
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100	io	MD NA		Ва	ltimo	re						1 <b>X</b> Yes 2 □ I
or 28	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen o	f What Cour	ntry?
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ione rthan "natural", or Itams 23a or 28a-1 show the Medical Examinat must be notified at	Funeral	11. Marital Status	Armed Fo		.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origi an, Mexican,	Puerto Rican	es or No- , etc.)		ack, White,	
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**ORIGINAL** 

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	Examin		4a. Facility Name (If not ins	IMORE	MEDICA	AL CI			4b. City, Town, TOWSON				I	County of D	ORE	
ų.	Funeral Director		5. Social Security Number 214-03-4516		x □ M 2 <b>X</b> F	7. Age	(In yrs. last b	Yrs.	If Under 1 Year Months Days		Min.	June 2	th Year)	.917	Country) Mary 1	and
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Division of Vital Becords. P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregn in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown	ant		birth 2 nant at ti	f pregnancy Fetal dea		Ectopic pregnan	су				23d. Date of Month	delivery Day	Year
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Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Alter this certificate has completely filled in by the funeral director, page 2	Certification;	2 Accident	Pending investigation Could not be determined	28e. Plac	e of Injur		farm, str	W	☐Yes 2☐N	lo	Bd. Describe  Bf. Location ( City or To	Street ar	nd Number o	r Rural Route	Number,
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	10		30. Name and address of Cyrus HAN	person who	MO	1380	)1 Yo	(Type,	Print)	50237 0(Veys	SVILL	e, M	12	2103	O	
	Sta Registi		31. Date filed (Month, Day	Year)	2004	Registrar	's Signature		g po	akes	*	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item #20b per in 6829 3/22/04 tes Registrar Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 58 M endo X /Medical If not institution, give street and number) 4c. County of Death cility Name Examiner Birthplace (State or Foreign
 Country) 6. Sex 7. Age (In yrs. ast birthday. cial Security Number **Funeral** 1 □ M 2 Ø F Months Days Hours Director Usual Residence of Decedent death with the Maryland 0d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-fehow other treumatic event, the Medical Examiner must be notified at 1 No 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 or items 23a or 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

\*\*LUMW Resource Cort 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. marked other then ry (0-12) College (1-4or 5+) oor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othing on yinjury or other treumatic event Spice. 17. Fath 's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Sumber, City or Town, State, Zip Code 20b. Place of Disposition 20c. Location - City or Town, State Method of Disposition V. Woodtawn Camer HING Memorial Burial 2 Cremation 3 R
4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licenses Vanu Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not Immediate Cause (Final disease or condition resulting in death) **Physician** 10 mon /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any locating Lorenze cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the attending physician and the dor use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 240 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2. No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deat 1 Natural Injury Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ţ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 10, 2004 ted cause of death (Item 23a) (Type, Print) 560 Loch Kaven was les

DHMH 17 Rev 1/2001

State Registrar (Month, Day, Yea 2 2 2004

32. Registrar's Signatu

State of Maryland / Department of Health and Mental Hygiene 2004 09068 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2040 M 16 2004 uanita March /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns pital Hopkins HOS Himore If Under 1 Year | If Under 24 Hr (In yrs. last birthday)

Yrs. 5. Social Security Number 6. Sex Age **Funeral** Days Hours 212.58.4282 1 M 2 F Director Usual Residence of Decedent Maryland 10b. County City, Town or Location 10d. Inside City Limits 10a. State or itams 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? deeth with 21213 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) Was Decedent Ever Armed Forces 1 Yes 2 No 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 M If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 2 No 1 Tyes 3 Widowed 4 Divorced "natural". 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retreat)

HOUSE KEEPING? 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: if item 27 ie marked other then Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) -ORENZO 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3708 SPRINGWOOD AVE, BALTO MD 21204 19a. Informant's Name/Relationship (Type, Print) DAUGHTER 3708 20c. Location - City or Town, Stete 20a. Method of Disposition Department of Financial Interportent: If its any injury or of once. 1 Burial 2 Cremation 3 Removal from State -BACTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility VAVGHN C. GREENE FUNERAL HOME 21. Signature of Funeral Service Licers 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTI MURE, MARYLAND 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months **Physician** /Medical Due to (or as a consequence of): Examiner Concer ervice if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 physicien IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day fo 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 99 1 Yes 2€No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2□ No 1 Yes 20 director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient Certification: To 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manne of Death 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No within 24 hours after death.

To the Funerel Diractor: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Descritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier les- 000 of person who completed cause of death, (Item 23a) (Type, Print) Hopkins Walfe St Johns Hospital 600 N 32. Registrar's Signature State Registrar

		1 - State AMEND ITEM #5 P.  1. Decedent's Name (First, Middle, Last		Cer	tificate of L	Jeath	2. Date of Dea	ath	3. Time of Death
Physic				iams			March	Day Ye	ear nors
/Medi Examii		Robert  4a. Facility Name (If not institution, give		Tamb	4b. City, Town, or	Location of Death	3 ACOL CAL	4c. County of I	
Exami	iei	Union Mem. Hospit			Balt	imore		NA	
Funeral Director		5. Social Security Number 6. Se		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Oa) 3-20-4		Birthplace (State or Foreig Country) N.C.
P .		Usual Residence of Decedent	140.00	_					
anylar	_	10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limit
88 - 1	ecto	Md. NA		Balti				40 000 000	Yes 2 N
with the	- E	10e. Street and Number			10f. Zip Code	) <u> </u>		10g. Citizen of Wha	t Country?
s 23	era	3612 Nineth St.	12. Was Decedent Ever in U.S	12 V	2122		acifu Vac or No-		American Indian,
72 hours after death with the Maryland natural', or Itams 23a or 28a-1 ahow dical Examirer must be notified at	Funeral Director	11. Marital Status  1 □ Never Married 2 X Married	Armed Forces?		Vas Decedent of Hi Yes, specify Cubai	n, Mexican, Puerto	Rican, etc.)		White, etc.
urs al	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	Black
72 hours "natural", oleal Ex-	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. Deced	ent's Usual Occupa	ition	ina	16b. Kind of Busin	ess/Industry
드 글 4	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	OO NOT use retired,	)	"'y		
	S	12th grade		Ope	rator Eng				Education
d a b	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumame)	
should be nd Mental marked o umatic ave	ိုင	Johnnie	Willi			Annie		Guyther	
12 sho h and 7 la ma		19a. Informant's Name/Relationship (T) Barbara L. William	1					r, City or Town, Sta	
s 1 and 2 should if Health and Mer item 27 la marke other traumatic		20a. Method of Disposition	20b. Pla	ce of Dispos	Nineth S		altimore	20c. Location - City	225
		1 XBurial 2 ☐ Cremation 3 ☐ F	Removal from State	metery, crem	atory or other place	9)			
permit. Page Department of Important: If any injury or once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>	1 001		Forest V			Randallst	
permit. Departr Imports any inje		27.50	/ Los			•		ore, Md.	21202
		23a. Part1. Enter the disease, or comp	lications that caused the death		tarch F.H		or respiratory arr	. North A	Approximate
hu salalası		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	7			1000		Interval Between Onset and Death
hysician /Medical		disease or condition resulting in death)	a. Myoccur die		nfarctio	m			
xaminer			Coronary	Av t	D:	SAM O			Type
30.5	Jer	Sequentially list conditions if any, leading to immediate	Due to (or as a conseque			20.4			1 YEAR
nd	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	С.						
physicien and the burial-transit	EX	resulting in death) Last	Due to (or as a conseque	ence of):					
physicien and the burial-transit	dicai		d						J
	a a	IF FEMALE:							1
e attending	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of	death 3 □	Ectopic pregnancy			23d. Date of Month	delivery Day Year
0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of dea 9 Unknown	ith 5⊔	Other (specify)				/
ed by detac		Part II. Other significant conditions co	ntributing to death but not result	ting in the un	deriving cause give	n in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
sign d be	d by	6.			. , , , , , .		1 🗆 Y	es 2 □ No 3 d	Probably 4 □Unknow
peen si	Completed						24a. Was a	an 24h War	autopsy findings availab
has ye 2	E G					····	autops	sy prior med? deat	to completion of cause of h?
	ပိ	25. Was case referred to medical				00.01	1 Yes	2 840 1 1	Yes 25≊0No
is certific director,	o Be	avaminar?	Hospital: 1 ☐ Inpatient	R/Outpatient	3□ DOA Othe	26. Place of Death			2
ਵ ਵ ਫ	-	27. Manner of Death	28a. Date of Injury 2	8b. Time of	28c. Injury	at at		ence 6 Other (S ow injury occurred	Бреспу)
r death. ector: After by the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day Year)	Injury	M 1 Y	? 'es 2 □No			
after death. Director: A	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom	ne, farm, stre	et, factory, office				r Aural Aoute Number,
Dire	Cert	4   Homodo	building, etc. (Specify)				City or Town	n, State)	
	edicai (	29a. Certifier Certifying Phy	sician: To the best of my knowl mer: On the basis of examinatio and manner stated.	ledge, death on and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occurr	and due to the c ed at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
24 hours 25 hours Funera	1 %	29b. Signature and title of certifier	and marrier states.		29c. License	number	2	9d. Date signed (M	onth, Day, Year)
o the Hospital thin 24 hours a the Funeral C	ž							11	
within 24 hours after of To the Funeral Direct completely filled in by	Ž	1//	MID	1	Dan	53270		Varah 11	2004
1	Ň	I for K				53373		Warch 16	2004
within 24 hours To the Funera	Me	30. Name and address of person who co	ompleted cause of death (Item 2				l'mor	March 16	3004

			State of Maryland / Departme	ent of Health and Mate of Death	lental Hygier	ne 2004	09050
	Physic /Medi Examii	cal	1 Ernest Paul Wells	ity, Town, or Location of Death	March	Day Year 19 2004 4c. County of Death	3. Time of Death  2'077 M
	Funeral Director	lei	Franklin Square Hospital Center	ROSEda, der 1 Year If Under 24 Hrs.	8. Date of Birth Dec. 199, 19	Baltine	e (State or Foreign
	e Maryland 3a-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Maryland  Baltimore  Fullerton				Inside City Limits
	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23e or 28e-f show event, the Medical Exercian are multiped at	Funeral Director	10e. Street and Number  5143 Terrace Drive  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Dec	Zip Code  21236  cedent of Hispanic Origin? (Spe pecify Cuban, Mexican, Puerto I		United Stat	es
-0036	hours after ntural', or Ite	by	3 ☐ Widowed 4XXDivorced If Yes, Give 1 ☐ Yes	s 2 <b>XX</b> No Specify:		Black, White, etc.  Specify: Whit	e
121215-0036	filed within 72 Hygiene. other then "ne	Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5+)  Car Sal  17. Father's Name (First, Middle, Last)	work done during most of working to the second seco	Au	Kind of Business/Indust	ry
Maryland	d 2 should be fi th and Mental It 7 Is marked of traumatic ever	To Be	P Ira William Wells  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addre		(First, Middle, Maide 1en Spann 1 Route Number, City		de)
Baltimore, M	of Heal		20a. Method of Disposition  20b. Place of Disposition (A cemetery, crematory of cemetery, crematory of cemetery).		ate 20c.	Maryland 21 Location - City or Town,	State
рапи	permit. Page Department Importent: II any injury o		21. Signature of Funeral Service Licensee 22. Name	and Address of Facility	al Home,	Inc.	D
14	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  ACUTE Response for a consequence of its part to final disease or condition resulting in death)  Sequentially list conditions	iratory F Preumonic	Failure	Inte	proximate erval Between set and Death
. Box 68/6U,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical Ex	d			23d. Date of delivery Month Day	Year
cords, P.O	The law requires that the diate has been signed by the page 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the ca	
	an: The law requilificate has been for, page 2 should	e Completed			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy fi prior to complet death?	tion of cause of
5	anding Physician: The lath. Tr. After this certificate has funeral director, page	ation: To B	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ E		e 5 Residence		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	ai Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)  29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and factors are in the page of examina	d at the time, date and place, as	City or Town, State	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
	To the Ho within 24 to To the Fu	Medical		on, in my opinion, death occurred	at the time, date and	d place, and due to the date signed (Month, Day,	cause(s)
	10,		30. Name and address of person who completed cause of death (Item 23a) Type, Print)  Dr Glenn Meininger Goo Franklin  31. Date filed (Month, Day, Year)  (22. Régustrar's Signature)	n Square Dri	ve Balti	More Md	21231
	Sta Registra		31. Date filed (Month, Day, Year)  ARR 2 2 2004			).	

DHMH 17 Rev 1/2001

Registrar

MAR 2 2 2004

			1 - For State Registrar	State of Marylar			of Heal			iene eg. No 20 (	09052
Diet.	Physici		1. Decedent's Name (First, Middle, Las	")	70	ion	es		2. Date of Dear	th Day 2	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give University of Ma	street and number) Media	al Cente	4b. City, T Ba	own, or Loca	ation of Death	- 1	4c. County of N/A	
, I	Funeral Director		5. Social Security Number 6. Security Number 191–26–3260A Usual Residence of Decedent	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months		ours Min.	B. Date of Birth (Month, Day, Dec. 17	Year)	9. Birthplace (State or Foreign Country) Pennsylvania
	Maryland a-f ahow	tor	10a. State 10b. County  MD Anne Art		ity, Town or Lo			.,,,,,,			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the a or 28s	Direc	10e. Street and Number 301 Mahogany Tra:	11		10f. Zip (	21032		1	0g. Citizen of Wh	at Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other traumatic avent, II a Medical Examinatic Examination and ODGE.	y Funeral Director	11. Marital Status 1 ★ Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:1956-	i		ent of Hispani by Cuban, Me	ic Origin? (Spec exican, Puerto R	ify Yes or No- ican, etc.)	14. Race -	American Indian, White, etc. White
Maryland 21215-0036	hin 72 hours s. in "natural" Medical Ex	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed (Specify only highest grad  Elementary/Secondary (0-12)	ucation	16a. Dece	dent's Usual kind of work DO NOT use	done durina	most of working	g	16b. Kind of Busi	
21	iled wit Hygiene ther tha nt, Ile	Соп	17. Father's Name (First, Middle, Last)	,	Field	Super				Construc	tion
ylano	ould be f Mental P mrked of	To Be	Anthony Zelones					ildred '			
Man	d 2 sho th and th am traum		19a. Informant's Name/Relationship (7) Thomas Zelones (1)							City or Town, St.	
ore,	of Heal of Heal fitem ?		20a. Method of Disposition  1 □ Burial 2 ★ Cremation 3 □	20b.	Place of Dispo cemetery, crei	sition (Name	e of	Da		20c. Location - Ci	
Baltimore,	nit. Pag artment prtent: I injury o		*4 □ Donation 5 □ Other (Specify  21. Signature of Euneral Service License	) Me	etro Cr	Name and	Address of F	3/18/.		Baltimor	e, MD
Ba	Depar Impo any ir		Datif f	M		Harde	esty F	uneral .	Home, P , Annap	.A. olis, MI	21401
	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Finat disease or condition resulting in death)	one cause on each line. a. metastat	ic ov					est.	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions.	Due to (or as a consect.							
o,	ate be executed only sician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consector) Due to (or as a consector)							
38760,	ficate be physici s the bu	dicai		d							
P.O. Box 6	The law requires that the death certificate be executed the sabeen signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pre				23d. Date of Month	
	w requires that been signed by should be deta	þ	Part II. Other significant conditions co	entributing to death but not re-	sulting in the u	nderlying ca	use given in F	Part I.		_	ute to the cause of death?
Division of Vital Records,	The law recate has been page 2 sho	Completed							24a. Was an autops perform	y prid ned? dea	re autopsy findings available or to completion of cause of other.  Ith?
Vita	sicien: Th s certificate lirector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	] ER/Outpatier	nt 3 DOA	Other	Place of Death		e) ince 6 □Other	(Cassifu)
ion of	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	ation: To	27. Manner of Death  1.XNatural 5 Pending 2 Accident investigation	28a. Date of injury (Month, Day Year)	28b. Time o Injury		c. Injury at Work?	28		ow injury occurred	(эрөспу)
Divis	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	( <b>fy</b> )				City or Town	, State)	or Rural Route Number,
	e Hospital 24 hours a e Funerel i letely filled	edical	29a. Certifier 1. Certifying Phy (Check only one) 1. Certifying Phy 2. Medical Exam	rsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at vestigation, i	t the time, da n my opinion	ite and place, and, death occurred	d due to the ca	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	n Karon H	D		License num		1		Month, Day, Year)
	12		30. Name and address of person who o	ompleted cause of death /Ita	m 23a) (Type	Print)	1771				, 2004
	10		Heidi Ann Karon Mi 31. Date filed (Month, Day, Year)	72 South o	Freenes	St. Ba	Utima	one, h	ID 21	201	
	Sta Registi		MAR 2 2 2004	32. Registrar's Sign	g sp	nake	/				

			_ FOI	nd / Department of Health and Me	ental Hygie	ne no. 2004	00052
			1 = State Registrar	Certificate of Death	Reg. 2. Date of Death	No. 2 U U 4	09053 3. Time of Death
	Physici-		1. Decedent's Name (First, Middle, Last) Henry A. A			Day Yeer 0 - 04	11:07 9 M
	Examin		4e. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth	
			Franklin Square Hospital Center	last birthday) If Under 1 Year If Under 24 Hrs.	0. Date of Birth	Da Himoi	
	Funeral		5. Social Security Nulmber 6. Sex 7 7. Age (In yrs. 217-12-7329 81	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye June 10,	er) Con	plece (Stete or Foreign intry) ryland
	Director		Usuel Residence of Decedent		Julie IV,	1922	
	yland		,	ty, Town or Location			10d. Inside City Limits 1 □ Yes 2 No
	e Mar	ctor	MD Baltimore	Middle River			
	ith th	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	intry?
	sath v	erai	13119 Miles Road  11. Marital Status 12. Was Decedent Ever in U	21220	city Yes or No-	14. Race - Amer	
10	72 hours after death with the Maryland nature!', or items 23a or 28a-f show lical Examiner mast be notified at	Funeral Director	1 ☐ Never Married 2 ☐ Married 1 🛣 Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto R	tican, etc.)	Black, White	
036	et', o	by	3 ₩ Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🖫 No Specify:		Specify:Whi	te
21215-0036	72 hc natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working)		. Kind of Business/I	ndustry
121	Mithin han	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	Legal Department	G	as&Elect	ric Co.
77	be filed within tal Hygiene. d other than "		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mei	den Sumame)	
en	id be ental ked o	To Be	Henry A. Arnold Sr.	Rebecca	9		
Henry Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Manaultonent, the Manaultone	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural	Route Number, C	•	
	as 1 and 2 of Health a item 27 is		Patricia Earll/daughter	13119 Miles Road Ba			
Arnold, altimore, N	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			cemetery, crematory or other place)		. Location - City or	
ti T	Pages tment of I tant: If it		`4 □Donation 5 □Other (Specify) Pd.	rkwood Cemetery 3/25		ltimore	
Bal	permit. Pages Department of Important: If I eny injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Cons			
		Г	23a. Pert1. Enter the disease, or on elications that caused the dea shock, or heart failure. List of yone cause on each line.	th not enter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician	0 1	Immediate Cause (Final disease or condition				Onset and Death
	Medical Examiner		resulting in death)  Due to (or as a consec	6			
le.		Ā	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Heart tailure			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c				
ó	be executed sician and burial-transit		resulting in death) Last Due to (or as a consec	quence of):			
8760,	cate be executed bhysician and the burial-transit	dicai	d				
9		/Mec	IF FEMALE: 23c. If yes, outcome of pregn	ancv		23d. Date of deli	vac.
P.O. Box	eath certific attending p	by Physician/Me	23b. Was decedent pregnant In the past 12 months?  1 Live birth 2 Fett	al death 3 Ectopic pregnancy		Month	Day Year
o.	t the d by the tached	hysic	1 Yes 2 No 9 Unknown 9 Unknown		· · · · · · · · · · · · · · · · · · ·		
	w requires that the deben signed by the should be detached	y P	Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part I.	23e. Did tobac		the cause of death?
ğ	v require been sig should b	ted			1 (XYes	2 □ No 3 □ Pro	obably 4 Unknown
Division of Vital Records,	law r nas be	Completed			24a. Was an autopsy performed	24b. Were au prior to death?	topsy findings available completion of cause of
<u> </u>	: The l cate ha				1 ☐ Yes 2 ☐	No 1 ☐ Yes	2 No
Vit.	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death Other: A Nursing Hom		s Понь - /о	
ō	Phys or this oral di	To To	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at 2	8d. Describe how	e 6 □Other (Specinjury occurred	ary)
ö	nding Phy tth. r: After thi e funeral	atior	1 ⊠Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury Work?  M 1 Yes 2 No			
Vis	or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At I building, etc. (Speci		81. Location (Stree City or Town, S	t and Number or Ru tate)	rai Route Number,
	ppital or Atten- ours after deatl eral Director: filled in by the	Cer					
P	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funcial Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of my kn (Check only one)  Medical Examiner and manner stated.	owledge, death occurred at the time, date and place, a ation and/or investigation, in my opinion, death occurre	ind due to the caus ed at the time, date	e(s) and manner as and place, and due	to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont)	-
	~		Di Vanhades 1	1.D HES00000		3/20/00	
	1,2		30. Name and address of person who completed cause of death (Ite	m 23a) (Type, Print)	Himara	Md 212	37
	St	ate	31. Date filed (Month, Day, Year)  32. Registrar's Sign		cillingiej	110 210	
	Regist	rar	MAR 2 3 2004	1. Angels			

ORIGINAL

DHMH 16 Rev 6/95

State

Registrar

10 N Chespe St BALtimore, MD 21201

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

D.0

32. Registrer's Signature

MICHAEL JAMES

MAR 2 3 2004

31. Date filed (Month, Day, Year)

			For State Registrar	i loude 1	State of Ma	aryland			f Health a			giene 0	04	09056
	Physici		Decedent's Name (Fin  L F NO	st, Middle, Last)	Zanks	5					2. Date of De Month		O*4"	3. Time of Death
	/Medic Examin		4a. Facility Name (If not	institution, give st.	reet and number)			4b. City. Town	Himus	of Death		4c. Coun	ty of Peeth	
	Funeral Director		5. Social Security Numb	6. Sex	7. Ag	e (In yrs. la 70	Yrs.	If Under 1 Ye Months Da		24 Hrs. Min.	8. Date of Bir Month, Da	th y, Year) - 33	9. Birth	place (State or Foreign
	nylend wow		Usual Residence of Dec 10a. State 10t	edent c. County		10c. City	, Town or Loca	ation ,	0.50					10d. Inside City Limits
	th the Ma or 28a-f	Director	10e. Street and Number	NA	- Du			10f. Zip Cod	YNE			10g. Citizen o	f What Cou	/ \
	oms 23a	Funeral [	11. Marital Status	North	Armed Forces?	-	6. 13. W	as Decedent	of Hispanic Or Juban, Mexican	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	14. Ra BI	ace - Ameri lack, White,	
900	d within 72 hours after death with the Marylend Jiene. r than "natural", or iteme 23a or 28a-f ahow the Medical Examiner must be neitified at	by	1 Never Married 3 Widowed 4	Divorced	1 □ Yes 2 1 If Yes, Give Year or Dates:	No.		□Yes 2		:		Spec	Olt	4CK
21215-0036	within 72 h ene. then *natu	Completed	15. (Specify of Elementary/Secondar	Decedent's Education of the Decedent of th	College (1-4or 5	5+)	16a. Decede (Give ki life. Do	nt's Usual Oc and of work do O NOT use re	ne during mos	st of workin	g	16b. Kind of	Business/ir	a Do
	be filed d other	Be	17. Father's Name (First	t, Middle, Last)	2 yks			WRO	18. Moth	er's Name	(First, Middle	Maiden Suma	111 )C ame)	466
Maryland	s 1 and 2 should t f Health and Ment item 27 is marked other traumatic	To	19a. Informant's No. e/	Relationship (Typ	e. Print)		19b. Mailing	Address (Str	eet and Numb	er or Rura	Route Numb	er, City o Tow	n, State, Zij	o Code)
	ges 1 and it of Health If item 27 or other tr		20a. Method of Disposit		moval from State		ace of Disposi metery, crema				AVE.	20c. Location	n - City or T	own, State
Baltimore	permit. Peges Department of Importent: If it any injury or o		4 □ Donation 5 □ 21. Signature of Funera	Other (Specify)		160	VIICUI	Name and Ad	Idress of Facili	7.26	ighn C	Green	e Fu	neral Shic.
	20 E 8 9		23a. Part1. Enter the di shock, or heart fai	sease, or complic lare. List only one	ations that caused cause on each li	the death	. Do not enter	the mode of	OCKTY dying, such as	cardiac or	respiratory a	(151) U	$\nu n, n$	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Fina disease or condition resulting in death)	a.	Due to (or as	a consequ	donusi ence of):	uf Ne	oplas	m (	unetac	July 1		aliver
	Examiner	ner	Sequentially list condition if any, leading to immediate. Enter Underlyin	ons, diate	Due to (or as	a consequ	rence of):							
ó,	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injur that initiated events resulting in death) Last	ў с.	Due to (or as	a consequ	ence of):							
09289	2 > 2	Aedical	IS COMME	d.									1	
P.O. Box	The law requires that the death certificativite has been signed by the attending phyoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mov 1  Yes 2 No 9  Unknown	gnant ths?	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3 □E	Ectopic pregna Other (specify					ate of deliv fonth	Day Year
	uires that the signed by	þ	Part II. Other significan	/ 1	ributing to death b	9	ilting in the und	lerlying cause	given in Part	l.		obacco use co Yes 2 □ No		the cause of death?
Records,	The law require ate has been sip page 2 should t	Completed		,	0						24a. Was auto perio	rmed?/	death?	opsy findings available ompletion of cause of
Vital		BeC	25. Was case referred t	-						e of Death	(Check only			
of V	hys this	2	1 Yes 2 No	Н			ER/Outpatient 28b. Time of	3LI DOA				dence 6 🗆 O		(fy)
Division	fter	Certification	2 Accident	Pending investigation	28a. Date of Inju (Month, Da	y Year)	Injury	М	njury at Work? 1 □ Yes 2 □	]No				
Divi	i Dit		4  Homicide	determine	28e. Place of Inj building, et	c. (Specify	"				City or To	wn, State)		al Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical		Certifying Physi Medical Examin	er: On the basis o	f examinat	ion and/or inve	stigation, in n	ny opinion, dea	ath occurre	d at the time,	date and place	a, and due t	o the cause(s)
	To the within To the comple	Me	29b. Signature and title	of certifie	(Inc			29c. Lic	ense number	7 /		29d. Date sign	ned (Month,	Day, Year)
	i		30. Name and address	of person who cor	nglieted cause of s	death (Item	23a) (Type, P	rint)	1275	69	15	3/1	1910	Day, Year)
	V Sta	ate	31. Date filed (Month, D	len Day, Year)	32. Phojstr	en ar's Signat	urth &	13	8 67	elme	1/10	e Ved		500
	Regist		8.8	AR 2 3 20	104	San San	- /							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death First, Middle, Last) 2. Date of Death 3. Time of Death Day Year MARCH 21, 2004 4:15 am<sup>™</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number Months Days Hours 218-36-371 Usual Residence of Decede 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X Nο et and Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No II Yes, Give 14. Race - American Indian, Black, White, etc. Married 1 Never Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) plege (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ella 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) Oc. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ethod of Disposition cemetery, Surial 2 ☐ Cremation 3 Removal from State bodlawa -04 □ Donation 5 □ Other (Specify) Preene laughn 22. Name and Address of Facility Approximate Interval Between Onset and Death CARDZOMYO PATHY ISCHEMI C Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an autopsy 2/2 No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 1 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

7 ie marked other than "natural", or items 23e or 28a-f show traumatic event, the Medical Example invalidad at Maryland 21215-0036 Pages 1 and 2 should be and Mental Department of Health a Important: If item 27 leany injury or other traigns permit. **Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burialattending physician for use as the buria P.O. Box 68760 Division of Vital Records, has been certificate within 24 hours after death. To the Funeral Director: After completely filled in by the

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

2

**Funeral** 

Director

the Maryland

21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Completed 25. Was case referred to medical examiner? Be Certification: To I 27. Manner of Death 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier MD 053430 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORTH CHARLES BALTIMORE CHAN M.D. 6701 STREET MARYLAND

State Registrar DHMH 17 Rev 1/2001 31. Date liled (Month, Day, Year)

32. Registrar's Signature

**ORIGINAL** 

2/206

		1	For State	State of Ma	aryland	•	rtment tificate			nd Me	_	giene Reg. No	200		<b>n</b> 9 n	58
3 4	*		Registrar     Decedent's Name (First, Middle, Last	it)						2.	Date of De	ath		•	3. Time of D	eath
	Physicia /Medic		Thomas Leon I	Burns						Ma	Month arch 1	7, Da			7:30 p	р М
)	Examin		4a. Facility Name (If not institution, give	street and number)			-		Location of	Death		40	. County of De	ath		
			1146 Sparrow Mil		- // /		If Under	Be1	Air If Under 2	4 Hrs o	Date of Bir		Harford		- (04-4	Camian
	Funeral Director		5. Social Security Number 6. So 118-09-1317	ex ⊠M 2□F /. Ag	e (In yrs. las 1.	Yrs.	Months	Days	Hours	Min.	Month, Da Oct. 8	y, Year,		r		r-oreign
3			Usual Residence of Decedent		+						JCL. C	, T.	JIJ Ha	гут	anu	
	ehow		10a. State 10b. County		10c. City,	Town or Loc	ation Air							10d.	Inside City	
	Ba-f e	Director	Md. Harfor	<u>a</u>	L	рет									1   Yes 2	M NO
	with the or 2		10e. Street and Number	1 Uorr			10f. Zip	2101	5				itizen of What C nited S			
	death with the Maryland ms 23a or 28a-f ehow	Funeral	1146 Sparrow Mil	12. Way	Ever in U.S.	13. V	Vas Deced			in? (Specif	y Yes or No		14. Race - Am			
	within 72 hours after death with the Maryla than "natural", or Itama 23e or 28e1 ehov the Marical Examinet must be notilised at	by Fun	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ If If Yes, Give Year or Dates: [	No		Yes, spec		Specify:	Puerto Rio	ean, etc.)		Black, Wh		ite	
212-0030	2 hou		15. Decedent's Ed	ducation		16a. Deced						16b. K	Cind of Busines	s/Indus	try	
מ	hin 7:	Completed	(Specify only highest gra	College (1-4or 5	5+)	life. E	OO NOT us	k done d e retired;	uring most o	of working						
7	be filed within tal Hygiene. d other than event, the M	Соп	12 years			wel	der	1					tee1			
and		Be	17. Father's Name (First, Middle, Last)  John Burns								First, Middle White		n Sumame)			
5	2 should and Men is marka raumatic	2	19a, Informant's Name/Relationship (	Туре, Print)		19b. Mailin	g Address	(Street a					or Town, State,	Zip Co	nde)	
Z Z	allth a		Joyce Ferguson/d			114	6 Spa	rrov	7 Mill	Way,	, Be1	Air	, Md. 2	101	5	
Jore,	(h) () b=		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		cen	ce of Dispos	atory or ot	her place		Date			ocation - City o			
altimor	permit. Page Department of Important: If eny injury of once.		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>		Hol	1y Hi				3/20/			ltimore L Air, 1			
ñ	Per		Bruin a	uleel	L								L Air, c, Md.			
П	145		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d the death. ne.	Do not ente	r the mode	of dying	, such as c	ardiac or re	espiratory a	rrest,		Ar	oproximate terval Betwe	en
)	Physician		Immediate Cause (Final disease or condition resulting in death)	a. chie	-	ali	tu	tu	- pu	lu		, el	m	UI.	nset and De	rain
	/Medical Examiner		Tosoking in dodain	Due to (or as	a conseque	nce of):			*		_	7				
	pe sit	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	à cui Sayua	nea of):										
>	xecution and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of):								-	_	-
3/60,	death certificate be executed e attending physician and id for use as the buriat-transit	dicai E		d			-									
õ	ntifical ng phi a as th	Medi	IF FEMALE:													
X Q Q	eath certifica attending pt I for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal d	eath 3 🗆	Ectopic pre						23d. Date of de Month	elivery Da	y Ye	ar
- -	the de y the a	Physician/Me	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of dea	in 5⊔	Other (spe	эспу)								
ς, Τ	w requires that the deben signed by the should be detached	by Pr	Part II. Other significant conditions of	ontributing to death b	ut not result	ing in the un	derlying ca	luse give	n in Part I.		23e. Did t	obacco	use contribute	o the c	ause of dea	ath?
ğ	en sig										1 🗆	Yes 2	!□No J□F	robabl	y 4 ∐Uni	known
Hecord	e s ci	Completed									24a. Was		24b. Were a prior to death?	utopsy	findings av etion of cau	alable ise of
_	Th ate pag		25. Was case referred to medical								1 ☐ Yes	2 🗆 No		s 2[	) No	
5	ysicia is certi directo	o Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2∏EF	R/Outpatient	3 🗆 🗅	Δ Cthe		_	Check only o		6 □Other (Sp	acih()		
ם ר	Attending Physician: r death. ector: After this certific by the funeral director,	1-	27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Da	ry 2	8b. Time of Injury		Bc. Injury Work	at				ry occurred	sciiy)		
<u> </u>	Attendir death. ctor: Af y the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				М		∕es 2 □ N							
DIVISION	P di de	Certification:	4 Homicide determined	289. Place of inj	ury - At hom c. <i>(Specify)</i>	ie, farm, stre	et, factory	, office		28f	. Location (. City or To		nd Number or F e)	iural R	oute Numbe	9 <i>1</i> ′,
		edical (		nysician: To the best niner: On the basis o and manner st	f examinatio											
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier				29c	License	number			29d. Da	ate signed (Mor	th, Day	v, Year)	
			Dans 5 2	)			E	3 3	2-15	)		Ma	CO H 18	20	04	
	6		30. Name and address of person who	0 C.	5 4	s, Re,		1,4,	/ \	5=1	AiR		21014			
-	Sta Registi		31. Date filed (Month, Day, Year)  MAR 2 3 2	32. Registr	rar's Signatu	re	1	100.1	/ /	ı						
2	-		7 G W THIN	UUT PUU	F - 100-	Pay	134	1446	01	01						

			Please		it in Black in			=	_	
			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i> a	artment of H rtificate of L		entai mygie Reg	2004	09059
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
	Physic		SHIRLEY	Ε.	BERGER		1	Month MARCH 2	Day Year 1 2004	6:30 P M
	/Medi Exami		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of Deet	
	Lxaiiii	iici	JOSEPH RITCHEY	HOUSE		BALTIMO	RE		N/A	
	Funeral		5. Social Security Number 6. S	_	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birti	place (State or Foreign intry)
P.	Director		216-18-5062	I□M 2∏F	79 Yrs.	Months Days	Tiodis Witt.	Dec.12 1		yland
	p .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
30	aryla ehov	-		_1.1 C-	Pasaden					1 ☐ Yes 2 ☑ No
9	788-1-	ecto		nder co.	rasaden			100	. Citizen of What Co	
9	with t	ā	10e. Street and Number			10f. Zip Code 2112	22	109	U.S.A.	and y:
3	death with the Maryland me 23a or 28a-f show court be couldined at	Funeral Director	210 Granada Road	12. Was Decedent I	Ever in IIS 13			ecify Yes or No-	14. Race - Amer	ican Indian.
	Te ter	Š	1 Never Married 2 Married	Armed Forces?	10		ispanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	Black, White	, etc.
7	0036 hours at tural, or	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify: W	iite
0	21215-0036 ad within 72 hours after death with the Marylan gleine. er than "natural", or Iteme 23e or 28e-1 ehow i, the Micdical Exeminer must be notified at		15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation during most of workii	16	ib. Kind of Business/l	ndustry
7	215 Pin 7	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+) (Give	DO NOT use retired	i)			_
-10	21 Signary Sig	Completed	8	0	Воо	kkeeper			Aluminium	Co.
43	nd in Hyper and	Be	17. Father's Name (First, Middle, Last,		. 1		18. Mother's Name	(First, Middle, Ma	Seitz	
	Via build b Ment arked	70	Frank L.	Marv			Anna			
6	Baltimore, Maryland 2121: permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mental pages.		19a. Informant's Name/Relationship ( Daniel W. Orem II						City or Town, State, Z Md. 21060	
Expiret	Heal Heal		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	D	ate 20	c. Location - City or	own, State
	ages ant of it: If i		1 🎇 Burial 2 🗋 Cremation 3 🗆 3 4 □ Donation 5 □ Other (Specif		Holv Gro	ss Cemete	ry 03/24	/04	Baltimore,	Md.
0	altin mit. F partm oorter injur		21. Signature of Funeral Service Licer	<del></del>			-		Home P.A.	
2	Department of the partment of		Jano (	1 Tack	unto	3204 Mo	-rolyniak untain ko	ad. Pasa	dena, Md.	21122
177	(PAUL)		23a. P Enter the disease, or com- nock, or heart failure. List only	plications that as sed	the death. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final	· ·	cancer					Onset and Death
	/Medical		disease or condition resulting in death)	Q.	a consequence of):					MONTIN
	Examiner			b						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of					
	760, e by executed sicien and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.						
X	by exe	Ě	resulting in death) Last	Due to (or as	a consequence of):					
2	876 sate b	dical		d						
CI	cords, P.O. Box 687  requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of preopancy				and Date of deli	
9	BOX death cer e attendir	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delin	Day Year
2	O he de	ysic	1 □ Yes 2,☑No 9 □ Unknown	9 Unknown	time of death 32	g Carda (specing)				
	ords, P.O requires that the een signed by th rould be detache		Part II. Other significant conditions of	contributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
( Just	ds urres sign ld be	d by	chranicobstructiva	- pulminar	disease			1 ☐ Yes	2 □ No 3 1 Pro	bably 4 Unknown
	ecords, law requires t as been signe	lete		/				24a. Was an	24b. Were au	opsy findings available
7	Relanne lange 2	Completed						autopsy performe	d? prior to c death?	ompletion of cause of
5	in: T		25. Was case referred to medical				26. Place of Death	(Check only one)	No 1 ☐ Yes	3L No
3	Vii rsicle	o Be	examiner?	Hospital: 1 Inpatie	nt 2□ER/Outpatier	ot all DOA Othe		1	e 6 Other (Spec	in Hospice
	on of Vital Recipions of Prisons and Physician: The law h. After this certificate has funeral director, page 2:	1-	27. Manner of Death	28a. Date of Injur (Month, Day	v 28b. Time o			28d. Describe how		27.11
5	ndin ath. r: Aft	atio	1. ■ Natural 5 ☐ Pending 2 ☐ Accident investigatio		/ Year) Injury		Yes 2 □ No			
	Division  or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, str	eet, factory, office	4	28f. Location (Stree City or Town, S	et and Number or Ru. State)	al Route Number,
	Disaft saft of in bed in									
	Division of Vital Re to the Hospital or Attending Physician: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical		nysician: To the best of miner: On the basis of and manner sta	examination and/or in					
	o the	Me	29b. Signature and title of certifier			29c. License			. Date signed (Month	
	7		> 95Tm 10	D		02	4170	1	March 22 re, MD:	, 2004
	3		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)	- A	7:1:	1.4%	
			E.Tso MD G	C. 01-07	spia 838	N.Eut.	aw St	Baltino	12, MD:	21201
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	4 1		a. **		

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryla	and / Depa	artment of H	lealth and Death	Re	g. No. ZUUL	
À	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Lase)     ANASTASIA     4a. Fecility Name (If not institution, give	BITZER		4b. City, Town, o	r Location of De	2. Date of Death Month MARCH	Year Year 2004	3. Time of Death
	Funeral Director	lei	Northwest Hospit 5. Social Security Number 6. Se	al Center	rs. last birthday) Yrs.	Randalls  If Under 1 Year  Months Days			Year) C	re thplace (State or Foreign ountry) at Britian
	Maryland a-f ehow	tor	Usual Residence of Decedent		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "naturel; or items 23a or 28s-f show any injury or other traumatic event, the Michael Examiner must be muilted at Ance.	by Funeral Director	10e. Street and Number 7102 McBeth Way 11. Marital Status 1 Never Married 2 Marned 35 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		10f. Zip Code  21784  Was Decedent of H If Yes, specify Cuba  1 Yes 2 No	ispanic Origin? an, Mexican, Pu Specify:		g. Citizen of What C U. S. A.  14. Race - Am. Black, Whi Specify: Wh	erican Indian, te, etc.
121215-0	iled within 72 hor tygiene. ther then "nature nt, no Mooreal	Completed by Funeral	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired erk	during most of v	vorking	Social Se	
arylanc	2 should be fi and Mental I- is marked of numatic ever	To Be	John Cullen  19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailir	ng Address (Street	Anast	asia Keane Aural Route Number,		Zip Code)
Baltimore, Maryland 21215-0036	nit. Pages 1 and 2 artment of Health ortent: If item 27 I injury or other tra		Catherine Hancock  20a. Method of Disposition  12/25urial 2   Cremation 3    4   Donation 5   Other (Specify  21. Signature of Funeral Service Licen	Removal from State M	p. Place of Dispo cemetery, crer t Paran	esition (Name of matory or other place Church C	em. 03/	20/04 R	oc. Location - City or andallstor	Town, State wn, Md. 21133 Directors In
Ba	permi Depa Impo any ii		23a. Part 1. Enter the disease, or compshock, or heart failure. List only of	olications that caused the de	87	728 Liber	ty Road	, Randalls	town,Md.	
8760,	Physician /Medical Examiner white price transit with the price of the	lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d.	equence of):	n tru	eum oi	Alb		
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pred 1 □ Live birth 2 □ Fo 4 □ Pregnant at time o 9 □ Unknown	etal death 3	]Ectopic pregnancy ]Other (specify)			23d. Date of de Month	iivery Day Year
Records, P.	wrequires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions or	ontributing to death but not r	resulting in the u	nderlying cause giv	en in Part I.		cco use contribute to	o the cause of death?
al Reco	ician: The law r certificate has be rector, page 2 sh	<b>Completed</b>	25. Was case referred to medical				OC Plane of C	24a. Was an autopsy performs 1 Yes 25	prior to death? No 1 □ Yes	utopsy findings available completion of cause of
sion of Vital	fing Phyen. After this funeral di	ation: To Be	examiner?  1 Yes 2 No  27. Manner of D ath  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien	28c. Injun Worl	er: 4 🗆 Nursing	Home 5 Residen 28d. Describe how	ce 6 Other (Spe	cify)
Division	the Hospital or Attending 24 hours after death the Funeral Director:	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Spe	crify)	n occurred at the tim	ne, date and pla	City or Town,	ise(s) and manner as	stated.
)	To the Ho within 24 r To the Fu completely	Medical	(Check only one) Medical Examone)  29b. Signature and title of certifier	iner: On the basis of exam and manner stated.	nation and/or in	29c. License		290	e and place, and due  1. Date signed (Mpnt	
	Sta Registr		30. Name and address of person who of all the state of th	ompleted cause of death (li	3373	Print) Jogat	40ER ( BUSTU	MEHTA	21133	

			Please I	State of Ma						-	/giene	e		_	
			1 - State Registrar			Certifica	te of L	Death			Reg. No	. 21	) O 4	0.9	306
	Physicia	เก	Decedent's Name (First, Middle, Last)     VIRGINIA JANE (							Date of De Month RCH	Da	, 200	Year 04		of Death
	/Medica	_	4a. Facility Name (If not institution, give	street and number)		4b. Cit	y, Town, or	Location of	Death		40	. County	of Death		
			UPPER CHESAPEAKE M	MEDICAL CE	NTER	В	EL AIF	7				HARFO	ORD		
	Funeral		5. Social Security Number 6. Sex		(In yrs. las	t birthday) If Und	er 1 Year	If Under 2	4 Hrs. 8. Min.	Date of Bi (Month, D	rth ay, Year,	)	9. Birthpi Coun	ace (State try)	e or Foreign
Н	Director		215-54-0291		55	Yrs.				3/24/			MARY	LAND	
	and	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Location							10	Od. Inside	City Limits
	dary!	ō	MD HARFORD		BEL	CAMP								1 □ Ye	es 2 No
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exam had not the notified at	Completed by Funeral Director	10e. Street and Number			10f. 2	Zip Code				10g. Ci	tizen of V	/hat Coun	try?	
	3a or	<u> </u>	1303 SANDWORT COUR	RT #203		21017						USA			
	death	era		12. Was Decedent E	Ever in U.S.	13. Was Dec			in? (Specif						
ယ	or Ite	Fur	1 ☐ Never Married 2 📉 Married	Armed Forces? 1 ☐ Yes 2 🛣 N	lo		eciry Cuba 2⊠ No	n, mexican, Specify:	Puerto Hic	an, etc.)			k, White,		
Š	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		I Tes	ZIZINO	<i>Specify</i> :				Specify	WHI	TE	
21215-0036	72 ho	ted	15. Decedent's Edu (Specify only highest grad	cation e completed)	1	(Give kind of t	nd of work done during most of working					b. Kind of Business/Industry			
212	ithin ie.	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT	use retired,	)	•				SECU TRATI		
	fited with Hygiene. other ther	S	12TH GRADE		-	CONTRACT	LING OF		la Nama //	Tienet Adjudants				OIV	
, pu	e d ita	Be	17. Father's Name (First, Middle, Last)					18. Mother				i Sumami	θ)		
<u>\Z</u>	should be nd Mental s marked o umatic eve	ို	HERMAN RUSSELL	0.74		405 14-17- 144-	(61-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-		INIA			as Taura	Ctata Tia	Codel	
Maryland	2 2 2 2		19a. Informant's Name/Relationship (Ty			19b. Mailing Addre			,,						~
	1 and 2 Health Health Sther tra		JEFF CLARK  20a. Method of Disposition	HUSBA		1303 SAI te of Disposition (A		I COOF	CI #a	_		AMP,	City or To	21017 wn. Stete	
<u></u> 0			1 E Burial 2 ☐ Cremation 3 ☐ F		cem	etery, crematory o	r other place								
Ę,	t. Pa ntmen rtant: njury		*4 □Donation 5 □ Other (Specify)		PAR	KWOOD CE		x s of Facility	26/2	JOHN:			RE, M		D A
Baltimore,	permit, Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licens	X Lune		2000001548		RAVEN				n, Mi		286	P.A.
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each lin	the deeth.	Do not enter the m			ardiac or re	spiratory	arrest,			Approxim Interval B Onset an	Between
7	/Medical Examiner		disease or condition resulting in death)	Due to (or as a		nce of):	(	5						ulear	_
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. Box	death cert e attendin od for use	Physician/M	in the past 12 months?	23c. If yes, outcome of the composition of the com	2 Fetal de	eath 3 Ectopic						23d. Date Mor	e of delive nth	ry Day	Year
P.0	that the		9 ☐ Unknown  Part II. Other significant conditions co	ntributing to death bu	ut not resulti	ng in the underlying	g cause give	en in Part I.		23e. Did	tobacco	use contr	ibute to th	e cause o	f death?
rds,		ed by								1 🗆	Yes 2	.∏ZNo	3 Prob	ably 4 [	Unknowr
ecord	e law re has be je 2 sho	Completed								24a. Wa	s an opsy	24b. V	Vere autop	sy finding	s available cause of
0	The I	Eo								perf	ormed?	d	leath?	21 No	
Vital		0	25. Was case referred to medical					26. Place	of Death (C	Check only	one)				
	Physician: rthis certificaral director.	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Anpatie	nt 2 EF	VOutpatient 3	DOA Othe	er: 4 🗆 Nur	sing Home	5 🗀 Res	idence	6 Othe	er (Specify	)	
n of	ng Ph fter th neral		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injur (Month, Day	y Year) 28	Bb. Time of Injury	28c. Injury Work			f. Describe	how inju	iry occurr	ed		
.0	Attending it death. ector: Alter by the fune	ath	2 Accident investigation			М		Yes 2 □ N							
Division	ospital or Attendi hours after death uneral Director: / y filled in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home. (Specify)	e, farm, street, fact	ory, office		28f	. Location City or To			er or Rura.	l Route Nu	ımber,
. –	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th com, letely filled in by the funeral	edical C		sician: To the best of ther: On the basis of and manner sta	examination										∍(s)
	o the	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D										Day, Year,	)	
			Administ	mi			DOC	4763	1		N	larel	21	, 200	4
	$\mathcal{O}_{r}$		30. Name and address of person who		eath (Item 2	3a) (Type, Print)						, , , , , ,		,	
	,		Antoinette Seve	mis mis	Uppe	Chesas	eahe.	Healt	h	Bel 1	Air	m	>		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	ar's Signato	· Boarde	1								
	Registr		MAR 2 3 20	14	Sind Stad	La Company									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 **Physician** MARCH 19 9:30 A M ANGELO PETER CHERRICO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES GENESIS ELDERCARE MAGNOLIA CENTER LANHAM | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | 12/14/1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1(XM 2□ F 86 578-07-2444 D.C. Director Usual Residence of Decedent filed within 72 hours after death with fhe Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene.
and it if team 23 a or 28e-1 ehov and it if it is not 28e-1 ehov and it is not a contact than "natural", or items 23a or 28e-1 ehov and it is not if it is not othat traumatic event, it is wedged Examples or that traumatic event, it is wedged Examples or that the notified at 1 ☐ Yes 2 No Completed by Funeral Director Prince Georges Bowie 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 12430 Shawmont Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Industry Baker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Donato Cherrico Carmela Cherrico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12430 Shawmont Lane, Bowie, MD Mrs Helen Cherrico / wife 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 3/22/2004 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Crownsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home 21. Signature of Funeral Service Licens 11101364 1 Second Ave SW, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRain **Physician** Carcinoma 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner physicien and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by Gerrone 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 1 ☐ Yes 2 ☐ No 1 Yes 2.8 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 👿 No ۵ 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 X Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: After the funeral py the f 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide fo the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signattire and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3119104 D2090 e and address of person who completed cause of death (Item 23a) (Type, Print) 30. Nam Bouice Fox Lane 14300 6 cell ans 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		1 - For State Registrar	State of Marylar		artmer rtificat					ene 2	004	
Physici /Medic Examir	cal		Campbell re street and number) Hospital		Lau	ce1	Location of D	) Death	Month March			eorge
Funeral Director		585-01-5411 Usual Residence of Decedent	7. Age (In yrs. 62	Yrs.	Months	1 Year Days	Hours N	viin.	Date of Birth (Month, Day, Y	<sup>(ear)</sup> 1941		hplace (State or Foreign untry)  Mexico
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show says injury or other traumatic event. I'm Medical Exactings must be rotified at once.	Director	Maryland Princ  10e. Street and Number		aurel	10f. Zip	Code			10g	. Citizen o	f What Co	10d. Inside City Limits 1 Yes 2 No
eath with	Funeral D	12203 Valerie La	ne	.S. 13.	Was Dece	2070 dent of His		? (Specify	Yes or No-	U.S.		ncan Indian,
ours after d ral', or item Examinar	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, spe 1 ☐ Yes		spanic Origin's n, Mexican, Pi Specify:	uènto Rica	ın, etc.)	Spec		e, etc. White
within 72 h iene. then *natu ina Medical	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+) 4+		kind of wo DO NOT u	rk done d se retired)	uring most of				Jnite	<sup>Industry</sup> d States Agriculture
ould be filed Mental Hygi arked other atic event.	To Be C	17. Father's Name (First, Middle, Last Edwin Abercrom					18. Mother's	Name (Fil	rst, Middle, Ma	iden Suma		
1 and 2 sho Health and em 27 is m		19a. Informant's Name/Relationship ( Mary Campbell  20a. Method of Dispose/for	(Wife)	12203	Vale	rie	Lane,			aryla	ınd	(ip Code) 20708 Town, State
nit. Pages partment of cortant: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Service Lice)	(y) Bal	t. Was	h. Cr	emat	!	20/20				ryland
Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	M012  polications that caused the deat one cause on each line.  Pneumonia					-			Mary	yland 20707 Approximate Interval Between Onset and Death  Week
/Medical  Examiner  bhysician and the burial-transit	dical Examiner	resulting in death)  Due to (or as a consequence of):  End Stage Lung Disease  Due to (or as a consequence of):  End Stage Lung Disease  Due to (or as a consequence of):  Probable Lung Cancer  Due to (or as a consequence of):  C.  Probable Lung Cancer  Due to (or as a consequence of):  d.										Months
w requires that the death certifica been signed by the attending ph should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pr Other (sp						ate of delin	very Day Year
requires that reen signed b hould be deta	þ	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying o	ause give	n in Part I.			cco use coi		the cause of death?
The far ate has page 2	Completed				_			-	24a. Was an autopsy performe 1 ☐ Yes 2 ☐	92	Were aut prior to c death? 1 \( \sum \text{Yes}	topsy findings available completion of cause of
Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 M No 27. Manger of Death		ER/Outpatien		Othe	r: 4 🗆 Nursin	g Home	5 Residence			sify)
To the Hospitel or Attending Phy within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral of	Certification:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b	e 290 Place of Injury At he	28b. Time of Injury	м		at ? ′es 2 □ No	28f. I	Describe how  Location (Stree	at and Num		ral Route Number,
tospitel or thours afte unerel Dir		29a. Certifier 1 Certifying Ph	nysician: To the best of my kno niner: On the basis of examina	wledge, death	h occurred	at the time	e, date and pl	ace, and	due to the caus	e(s) and m	nanner as	stated.
To the l within 2. To the I	Medical	29b. Signature and title of certifier	and manner stated.		290	. License	number		29d	Date sign	ed (Month	o, Day, Year)
171		· Col	Affr	7		D254				larch	18,	2004
10,		30. Name and address of person who Robert Maggin, 1	MD 6		Ĺ	aure1	Baltin L, Mar	nore cylan	Avenue d 20707	,		
Sta Registi		31. Date filed (MonMAR Y297)3	2004 32. Signaturi's Signa	J. A	house	9						

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200

		,	Certificate of Death	Reg. No. 2 (	09065							
	Physician	Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Dey	Year 3. Time of Death							
-	/Medical	MARIE G COMM		March 18, 20	04 6.394							
	Examiner		4b. City, Town, or L		of Deeth							
		St. Agnes Hospice	Baltimore									
1	Funeral Director	5. Social Security Number 6. Sex 7. Age ( <i>In yrs. less</i> 1 M 2 F 85	t birthday)  If Under 1 Year  If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Dey, Yeer) 10–13–1918	9. Birthplace (State or Foreign Country)  Maryland							
	pu 🖈	Usual Residence of Decedent  10a. State 10b. County 10c. City, 7	own or Location		10d. Inside City Limits							
	death with the Maryland ms 23a or 28a-f show finast be notified at neral Director		onsville		1 ☐ Yes 2 ☑ No							
	iter death with the Mar r items 23s or 28s-f si direr must be notified Funeral Director	10e. Street end Number	10f. Zip Code	10g. Citizen of	What Country?							
	¥ P				,							
	lera lera	900 S. Rolling Road 11. Meritel Status 12. Was Decedent Ever in U.S.	21229 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	ce - American Indien,							
0		Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 → No	If Yes, specify Cuben, Mexican, Puerto	Rican, etc.) Bla	ck, White, etc.							
07	by by	3 ₩idowed 4 Divorced If Yes, Give Year or Detes:	1 ☐ Yes 2 ☑ No Specify: Specify. White									
Maryland 21215-0020	ed within 72 hours efter ygiene. er than "natural", or its it, the Medical Expraine Completed by Fu.	15. Decedent's Education (Specify only highest grade completed)	6e. Decedent's Usuel Occupation (Give kind of work done during most of work	16b. Kind of B	usiness/Industry							
21	in and old	Elementary/Secondary (0-12) College (1-4or 5+)	`life. DO NOT use retired)									
2	A transfer	10	Home Maker	Own Ho								
pu	be filed with that Hygiens dother the event, the Be Corr	17. Father's Neme (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden Sumar	ne)							
yla			Anna	Marie Seidlich	1							
a	d 2 should th and Mer 7 is marke traumatic	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run	al Route Number, City or Town	State, Zip Code)							
	s 1 and f Health ftsm 27 other tr		2407 Clydesdale Road	Finksburg, Man	yland 21048							
ore	ges 1 it of H if itar or oth	20a. Method of Disposition  1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State	e of Disposition (Name of etery, crematory or other place)		City or Town, State							
<u>E</u>	Pag ment ant: b	4 □ Donation 5 □ Other (Specify) Balto	l l	3/21/04 Laure1,	-							
Baltimore,	permit. Pages Depertment of Important: If i eny injury or DRGe.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Lon	ing Byers Fune	ral directors							
ш	70 E 2 9	( MeSt 331, 60)	8728 Liberty Road,	Randallstown, M	D. 21133-4784							
		23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between							
and a	Physician				Onset end Death							
46	/Medical	Immediate Ceuse (Final disease or condition	RATION PNEL	MONIA								
	Examiner	resulting in death)  Due to (or as	s a consequence of):									
	ie d	D45	PHA GIA									
	ficete be executed 3 physician end ss the bunel-transit edical Examiner	Sequentially list conditions,  Due to (or as	a consequence of):									
00	death certificete be execu e ettending physician end ad for use es the bunel-tra sician/Medical Exar	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury C. ATHEROS CLEROTIC CV DISEASE										
68760,	the t	Cause (Disease or injury that initiated events resulting in death) Last										
	≥ وأيا											
Box	leath certifice ettending ph d for use es t Ician/Med	_ (,										
	the e	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Pert I.	23b. Did tobacco use co	ntribute to the cause of death?							
P.0	The law requires thet the death certicate has been signed by the ettendin page 2 should be deteched for use Completed by Physician/N	LEAKING AAA		1 ☐ Yes 2 ☐ No	3 □ Probably , Onknown							
Division of Vital Records,	signe si signe signe si si si si si si si si si si si si si				Odb. Missa sutanau findinas							
0	een seen should			24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause							
ec	has b ge 2 si				of death?							
H	The la			1 Ves 34 No	1 ☐ Yes 2 ☐ No							
/ita	ysician: The s certificate director, pag To Be Co	25. Was case referred to medical examiner?		h (Check only one)								
7	Physician: this certificated director,	1  Yes 2 No Hospital: 1 Inpatient 2 ER		me 5 ☐ Residence 6 ☐ Oth								
Ē	ng P uner	1 Vaturel 5 □ Pending (Month, Day Year)	Injury Work?	28d. Describe how injury occur	red							
sio	leath lor: A the f	2 Accident investigation 3 Suicide 6 Could not be 288 Place of Injury At home	M 1 Yes 2 No	001 1 12 101 11 11	0.10.11.1							
<u>≥</u>	ther direct in by in by	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street end Numb City or Town, Stete)	er or Hurai Houle Number,							
	urs a urs a lilled i	20.0.45.4										
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funerel di Medical Certification: To	29a. Certifier (Check only one)   Check one)   Check only one)   Check only one)   Check only one)   Check										
	thin 2 the maple	one) and manner steted.  29b. Signeture and title of entitier	29c. License number	29d Date signe	d (Month, Day, Year)							
	N N N N N N N N N N N N N N N N N N N	2 Clevert) Mr	1		0 1							
	1		2045145	FERRENDE	- 140							
	0	30. Name and address of person who completed cause of death (Item 23	e) (Type, Print) Rodolfo E 162 Cotonsville	MD21228	ענייון							
		31. Date filed (Month, Day, Year) 33. Registrer's Signature		17 2122								
	State Registrar	MAR 2 3 2004	Brock 1									

State of Maryland / Department of Health and Mental Hygiene 2004 09066 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** LIZABETH March 19 2004 /Medical 4a Fecifity Neme (If not institution, give street and number) 45. City, Town, or Location of Deeth 4c. County of Death Examiner HOSPITAL HUNder 1 Year BALTIMORE SPECIALTY UNIVERSIT If Under 24 Hrs. 5. Social Security Number 218-09-39 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) Birthplace (Stete or Foreign
 Country) **Funeral** Months Days 1 □ M 2 12 € 6 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the 17 is marked other than "natural", or harman any Injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1/SYes 2 □ No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 4 BEND KD. USA. 14. Race - American Indian, Funeral 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Bfack, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 Divorced Be Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mentary/Secondary (0-12) Colfege (1-4or 5+) WORKER JOHNS HOPKINS UNIVERSITY 17. Fether's Neme (First, Middle, Last) (UN KNOWN) 18. Mother's Name (First, Middle, Maiden Sumame) (M N ~ にいどいのかれ ANNIE BELL 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) NORTH BEND RD APTZA BALTO, MO. 21229 MORRIS ANDREWS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 □Removal from State 3-24-04 ARBUTUS, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Fecility BROWN JR, FUNERAL HOME 2140 N. FULTON AVE. BALTIHORE 1402121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** /Medical fmmediate Cause (Final diseese or condition resulting in deeth) 10 million Cardiac amythamos Examiner Due to (or as a consequence of): Physician/Medical Examiner heart diseane orthoroselerche or Attending Physician: The law requires that the death certificate be axecutive usa as the burial-transit Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): .09289 Due to (or as e consequence of) Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Chronic monel feelure on Hemochalysis 1 Tes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? TLYes 2LENO 1 ☐ Yes 2 ☑ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28e. Date of Injury (Month, Day Year) 27. Manney of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Funeral Director: After completely filled in by the funer 1 Naturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 Ro104 D 30494 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) CX DESAIMO uni. specifity hespitel Gol Sath Charles St Baltimore MD 21230 State Registrar

State of Maryland / Department of Health and Mental Hygiene  $200 \, \mathrm{hz}$ 09067 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Elizabeth V. Copley March 22 2004 7:30 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County Memorial Hospital Oakland Garrett | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Oay, Year) | Jan • 22, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 212 34 6928 81 1923 Director Virginia Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show r than "natural", or Items 23a or 28a-f shov The Medical Examinar must be notified at 1 Yes 2 □ No Directo Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3717 S. Hanover Street 21225 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ⋧ 3 ☐ Widowed 4 1 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil ment of Health and Mental H tent: If item 27 Is marked otl Hubert Miller Florence Sensabaugh 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Fangman / Daughter 121 Linwood Avenue Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Meadowridge Mem. Park 3/25/2004 | Elkridge, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ANCER 6 months VARIAN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olesaso or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial Box 68760 Completed by Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) the bed Records, P.O. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA ို this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27205 th S.T. OAKLAND, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHWALM E, 311 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Even & foot Registrar

State of Maryland / Department of Health and Mental Hygiene 00 4 09068 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** FFFIE CHAMBLI SS MARCH 2004 10:20 AM 19 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore HOSPITAL NOITHWEST randa own If Under 1 Year Birthplace (State or Foreign /Country) 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 💢 F 76-0158 Director Jan. Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f ahow other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 □ No Varyland Director more 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 6 2/2 or itams 23a Funeral 10 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 S If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Completed by 3 X Widowed 4 □ Divorced a "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 is marked other than 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nea 19a. Informant's Name/Relationship (Tyle, Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3127 Md. 2120' 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Himportant: If ite any injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2004 GreenMount Crematory \*4 □ Donation 5 □ Other (Specify) 22. Name and Address of Cility Fuse Full Coseph L. Russ Full 222 W. North Ave. 21. Signature of Funeral Service/Licensee once. tuneral Ho Home Approximate Interval Between Onset and Death HEPAT Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEPATITIS Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ IMMUNODEFICIENCY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 nknown Completed RENAL CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🖎 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 ☐ Accident the within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospitei 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54352 2004 MARCH TODOK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRCEA tos PithL 5401 OLD COURT ROAD MD 21133 NORTHWEST RANDALLSTOWN 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 09069 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **1**8 □ Day 3. Time of Death **Physician** Month 2004 Year Margaret Gosnell March 2:28a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carrol1 Carroll Hospital Center If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□M 2₽F Yrs. Director Md 261-70-9509 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or items 23e or 28e-f show traumatic event, the Medical Examinar must be notified at Md Carroll Westminster 1 No 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 52 1/2 Carroll Street 21157 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e any Injury or other traumatic event, the Menters USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2V No If Yes, Give A Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry domestic/child care Elementary/Secondary (0-12) College (1-4or 5+) homemaker/foster parent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Gosnell Lilly Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Maiden Choice Ln., Baltimore, Md 21228 Margaret Day Martin (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 3-22-04 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Paige Haight P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Acute myocardial infarction Due to (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ diabetes mellitus type 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform rmed? 2X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide

signed by the attending physician and do detached for use as the burial-transit requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, page 2 should be peen certificate has To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica funeral director. filled in by

with the Maryland

29b. Signature and title of certifier unkam NU)

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) J 117040

March 18, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 215 Washington Heights Medical Center, Howard G. Lanham, 31. Date filed (Month, Day, Year) 32. Registrar's Signature Westminster, MD 21157

📭 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29a, Certifier

(Check only one)

State of Maryland / Department of Health and Mental Hygiene 2 1 1 09070 Certificate of Death 2, Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** 4:30PM M Rev Dean March 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) Examiner Mariner Health of North Arundel Glen Burnie Anne Arundel 8. Date of Birth (Month, Dey, Year) Nov. 25,1914 ff Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplece (State or Foreign Country) Columbia 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 M 2 X F 89 189-28-7191 Director Usual Residence of Decedent death with the Manyland 10d. Inside City Limits 10c. City, Town or Location 10b. County 27 is marked other than "naturel", or iteme 23a or 28a-f show traumatic event, the Modical Extrainment result to nightiliad at 10a. State 1 ☐ Yes 2 No Director Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21108 U.S.A. 296 Chalet Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Item eny injury or other traumatic excess. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2□ No Specify: Specify: Hispanic þ Columbian 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Elementary/Secondary (0-12) Nurse Hospital 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Paulina Lopez Samuel Rey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 296 Chalet Drive, Millersville, Maryland 21108 Mrs. Mary K. Flannery / daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5) Other (Specify) Chesapeake Cremation | Mar 20,2004 Stevensville, MD ⁴ 4 □ Donation 21. Signature of Furneral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. mo1319 1 Second Avenue S.W., Glen Burnie, MD 21061 Approximate Interval Between 23a. Pert1. Enter the disease, or complications that carried the death, shock, or heart failure. List only one cause or, each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final vien 14 **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner mary POI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit the death certificate be executed and Due to (or as a consequence of): physician 68760 Physician/Medical as the t attending Box IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown s been signed by the should be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: 24 hours after death. Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2710 ٩ 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 24 hours 1 Fertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 To the I To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) Land 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Sens MAR 2 2004 Registrar

Amend Item #984a State of Maryland / Department of Health and Mental Hygiene 2004 Las Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day **Physician** 8 2004 11:26 DM /Medical Zecility Names (Inclinstitution Five street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 24 Hrs. 8. Dat Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 32-071 Days 1 2 F Months 69 Yrs. Director КŸ Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Funeral Director Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 24 Tussock Ct. 21220 U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pegas 1 end 2 should be filad within 72 hours after on ant of Heelth end Mentel Hygiene. ant: If flem 27 Is marked other than "natural", or ite Black, White, etc. 1 Never Married 2 Married 1 XYes 2 □ No If Yes, Give altimore, Maryland 21215-0020 1 Yes 2 No Specify: White. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12th Grade College (1-4or 5+) Foreman Steel Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Walker Dingus Margaret Hampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Dingus 24 Tussock Ct., Baltimore, MD (wife) 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of important: if it any injury or one 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Cem. 3/24/04 Owings Mills, MD 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ician and bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ physician a Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) attending pt for use as t Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 2 certificete has been si irector, pega 2 should i 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? 1L Yes 1 ☐ Yes 21 No or Attending Physician: the funerel director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To efter death.

Director: After this 27. Manner of De M 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 11 1 ☐ Yes > No 2 ☐ Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Stre t and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital of within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) m augs 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Alameda Baltimare 3901 T Luons State Registrar

	Phy: /Mi Exa	sicia edic min
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be elected within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	State Registrar				Cei	rtificat	e of D	eath	T :		.20	14	09	U1:	
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ł	Usuel Residence of 10a. State	10b. County		10c. City	Town or Lo	ocation				10d			Od. Inside (	Dity Limit	
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b) lameral encount	10e. Street and Nur	mber		•			10g. Cit	tizen of Wh		-					
	3606 Ken	yon Avenu			21213							u. s. A.			
	11. Marital Status	ied 2 🕅 Married	12. Was Decedent Armed Forces? 1 X Yes 2 □		5. 13.	Was Deced	dent of His cify Cuban	panic Origin? (S , Mexican, Puer	pecify Yes or N to Rican, etc.)	0-	14. Race - American Indian, Black, White, etc.				
	3 Widowed		If Yes, Give Year or Dates		974	1 🗌 Yes	2X) No	Specify:			Specify:	Whi	te		
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	17. Father's Name	(First Middle   ast)	ž Yea	rs	Substance Abuse Counselor T.  18. Mother's Name (First, Middle, Ma							reatment Center			
י מכן		. Daugher	+.,						e Layto		, Darria iro	,			
2		ame/Relationship (Ty			19b. Mailir	ng Address	(Street a		Iral Route Numb		or Town, S	tate, Zip	Code)		
	Donna Da	ugherty (V	vise)		3606	Keny	on Au	enue, B	altimor	e, Ma	aryla	nd 2	21213		
1	20a. Method of Disp	position Cremation 3 🗆 F	lemoval from State	1 00	ace of Dispo metery, crer	osition (Nai matory or c	ne of other place	)	Date	20c. L	ocation - C	ity or To	own, Stete		
	1 4 □ Donation	5 ☐ Other (Specify)		Bay	view C		_		/2004					.nd	
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Schimunek Funeral Hom 3331 Brehms Lane, Buttimore, Maryland														
	22 Dans Salars	he disease, or compl	inations that assume	d the death				-			malyr	anu	Approxima		
	shock, or hea	n failure. Last only or	ne cause on each li	ine.			io oi dying	30071 03 001 010	5 51 105pa.to.; y	, , , , , , , , , , , , , , , , , , ,			Interval Be Onset and	etween	
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resulting in death) Last Due to (or as a consequence of):															
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Filysicialivimedic	IF FEMALE: 23b. Was deceden	t pregnant	3c. If yes, outcome								23d. Date	of delive	ery		
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	9 🗌 Unknown		9⊡ Unknown							ŀ					
ολ	Part II. Other signif	ficant conditions co	ntributing to death b	out not resu	lting in the u	inderlying o	ause give	n in Part I.					ne cause of	death? Unknow	
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Completed									24a. Was		pri	ere auto or to co ath?	psy findings mpletion of	s availab cause of	
									1 Yes	21⊡ No			2 🗆 No		
2	25. Was case refer examiner?		lospital: 1 ☐ Inpati	ent 2 🗆	R/Outpatier	at 30 00	Otho		ath (Check only dome 5 Res		€ □Other	/Specif	14)		
	1 ☐ Yes 2 🗙 27. Manner of Deat	th	28a. Date of Inju	ury	28b. Time o		28c. Injury	at	28d. Describe				y)		
	1 XNatural 2 ☐ Accident	5 Pending investigation	(MONIN, Da	iy 1801)	Injury	М	Work¹ 1 □ Y	es 2 □No							
2	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In building, e	jury - At hor tc. (Specify	me, farm, str	reet, factor	y, office		28f. Location City or To			or Rura	il Route Nui	mber,	
cermicanon.	2-199-20-2-														
Cal	29a. Certifier (Check only	1X Certifying Phy 2 ☐ Medical Exami	ner: On the basis of	of examinati										(s)	
one) and manner stated.											te signed	(Month,	Day, Year)		
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Me		11-16-1	V			J	סומ	1402	1	MAL	2CH 19	9. 2	004		
Me	30. Name and addi	ress of person who	ompleted cause of	death (Item	23a) (Type.	Print)	D19	402		MAI	RCH 19	9, 2	2004		

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 09073 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 9:39 A M March 22, 2004 Ellsworth William /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1M M 2□ F **Funeral** 22, 1932 Washington, DC 219-28-6650 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "naturel; or Iteme 23e or 28e-f ehow the Medical Exercines must be motified at 1 ☐ Yes 2 No Director MD Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 114 Greenmeadow Dr. 21093 USA permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23a eny injury or other traumatic event. Its Mental and 10 a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 1 ☐ Never Married 2 Marned 1X Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Transportation Foreman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Ellsworth Freida Seeger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Audrey R. Dix/Wife 114 Greenmeadow Drive Timonium, MD 20b. Place of Disposition (Name of cometery, crematory or other place)
Dulaney Valley
Memorial Gardens March 25, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 ¹ 4 □ Donation 5 □ Other (Specify) Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 21. Signature of Funeral Service Licens e wichael J. Flagle 10 W. Padonia Road Timonium, MD 21093 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death arter Immediate Cause (Final wway Means Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year be detached for 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 A ER/Outpatient 3 □ DOA Certification: To 1 🗌 Yes filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Hospital or Attending 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 034521 Mark 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. degistrar's Signature Suite | Hunt Valley, MD 21031 Dr. Mark Lawos, M.D. 31. Date filed (Morith, Day, Year) MAR 2 3 2004 State Registrar

Robert Dupey Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 1914State of Maryland / Department of Health and Mental Hygiene AKG 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2:50 P March 17. 2004 /Medical 4a. Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months -68 1**X**M 2□ F Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan arthent of Heath and Mental Hyglene ortants if itam 27 is marked other then "natural", or Itams 23a or 28a-f show injury or other traumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event, itam Medical Estimate in Institute or other praumatic event. 1 Yes 2 □ No Director Maryland more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 Marned 1 ☐ Yes 2 No altimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pente 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 2/2/ 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 MBurial 2 ☐ Cremation 3 Removal from State Department of Important: If eny injury or \* 4 Donation 5 Other (Specify) tamil inia 122. Name and Address of Facility
JOSEPH L. RUS
2222 W. NOTTH 21. Signature of Funeral Service Licenses uner 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reviosa **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 1 Yes 2 □ No 24a. Was an cate has autopsy performed certificate 2 No Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ XYes 2 No 2 X ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending 1 □ Yes 2 □ No death. investigation the within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) ture and title of/certifier 29b. Signy O.C.M.E. March 18, 2004 3 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name LOCKE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
MAR 2 3 2004

**ORIGINAL** 

32, Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1.30 A M March 7,2004 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Utinose Rehabilitation = Xtinded

cial Security Number 6. Sex, 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of B Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 241 32 8822 SEptember 23,1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 Yes 2 No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23225 115.17 804 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No If Ves, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ② No Specify: It Ves, Give Year or Dates: 1950-1952 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BEHY DOIES Douglas Demoky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 804 Fuge Edmands St Kichmond, Va Kubert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State JARNSON FOREST COMETERS : 3/23/04 \*4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BEHS Funerul Home 21. Signature of Funeral Service Licensee Beds 1129 N. CARDINE ST BOURDER MD 21213 atucia 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Pai 25 27

the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 2 should be detached signed by page, To the Hospitel or Attending Physician: within 24 hours after death.
To the Funeral Director: A
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Be Completed by Physician/Medical Examiner

Medical Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r then "naturel", or iteme 23s or 28e-f ehow the Medical Exercit set must be notified at

nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortant: If Item 27 is marked other then injury or other treumatic event, the Me

permit. Page Department of Important: If eny injury or once.

Physician /Medical **Examiner**  Directo

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filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

t II. Other significant conditions of			g cause given in Part 1.	23e. Did tobacco t	use contribute to the cause of death?
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. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1 Anpatient 2	ER/Outpatient 3	Other	ath (Check only one)  Home 5 Residence	6 □Other (Specify)
. Manner of leath  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injur	ry occurred
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h Signature and title of certifier		29d. Da	te signed (Month, Day, Year)		

State Registrar

31. Date filed (Month, Day, Year) MAR 2 3 2004

AUGUSTUN CHYUL

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

vd. Boltmer MD 2/2/2 3300 Lock Raven Of party

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item #17, per FH,G839 and of Man Band / Department of Health and Mental Hygiene

1- For AMEND Item#23 PartII, per DR,G829,3/23/24/25/Certificate of Death

Reg. No. Reg. No 200 L 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month **Physician** 11:20amм March 16, Joseph Frederick Engel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Forest Glen Nursing Home Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Yrs. New York 1912 91 6, Director 064-12-7323 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar nent of Health and Mental Hygiene. Survivily to Health and Mental Hygiene. Survivily, or Items 23a or 28e-1 show and: If them 27 is marked other then "naturely, or livens 23a or 28e-1 show and it is the controlled. It is the control to a routilized. 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 U.S.A. 3338 Chiswick Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grumman Aerospace Design Engineer 2+18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CHARLES ENGEL Evelyn Gagnon Engel--Chase ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3338 Chiswick Court, Silver Spring, Maryland 20906 (Wife) Jeannette C. Engel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Balt./Wash. Crematory 3/19/2004 Laurel, Maryland 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility <sup>22. Name and Address of Facility</sup> Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 MO1250 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ønset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medlcai IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No. should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PNEUMONIL s certificate has b lirector, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Andrising Home 5 Residence 6 Other (Specify) 1 Yes, 2 No 1 Inpatient ٥ 2 ER/Outpatient 3 DOA in by the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death | Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours af 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO667 UKMU M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3309 WHEAM MO 32. Registrar's Signature 31. Date file (1900)h. State Registrar

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36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event, tha Medical Eventual matter trial be rectified at	by Funeral Director	9270 Cherry Lane, Apt. 65  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Ammed Forces? 1 Yes, Give 17 Yes, Give 17 Yes, Give 17 Year or Dates:	20707  Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F		S . A .  14 Race - America Black, White, e	tc.
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O. BOX 68/60	death certifi e attending id for use as	hysician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month D	ay Year
cords, P	w requires that the sbeen signed by the should be detached.	by P	Part II. Other significant conditions contributing to death but not resulting in the Coronary Arkey Discary  Amenica		23e. Did tobacc	co use contribute to the	cause of death?
Ď L	≥ 0.22	Completed			24a. Was an autopsy performed 1 Yes 2	prior to comp death?	y findings available pletion of cause of
sion of Vital	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ertification; To Be	25. Was case referred to medical examiner?  1			6 □Other (Specify)	
DIVISION	pital or Attuurs after de eral Directo	O	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, Sta	,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat (Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.  29b. Signature and title of certifier	vestigation, in my opinion, death occurred	at the time, date a	and place, and due to the	e cause(s)
	. > F 0	1	30. Name and address of person who completed cause of death (Item 23a) (Type,	D28998 Print) PRITAM S I Lawof M	SAINI	3-14-04	,
T.	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 Lampe m	0 207	708	
	Registra		MAR 2 3 2004 Anews 19	Sporks .			

		1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of rtificate o	f Health and of Death	d Mental Hy	giene2 (	004	09	079
Physic		Decedent's Name (First, Middle, Las     ABRAHAM	t)	FRE	EDLAND		2. Date of De Month MARCH	Day	2004	3. Time o	of Death P M
/Med Exam		4a. Facility Name (If not institution, give	ME		4b. City, Town		eath		ity of Death		
Funera Director		5. Social Security Number 6. Security Number 218–22–0660	ox 7. Ag	95 Yrs.	If Under 1 Ye Months Day		in. 8. Date of Bi	1908		place (State of	or Foreign
ne Maryland 8a-f show	Director	MD 10b. County		10c. City, Town or Lo						10d. Inside C	City Limits
3a or 2	i Dire	10e. Street and Number 3601 GREENWAY			10f. Zip Cod			10g. Citizen o		ntry?	
and 21215-0036  be filed within 72 hours after death with the Maryjand stall Hygiene.  Id other than "natural", or Items 23a or 28a-f show event, the Madical Examinar must be notified at	d by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:	No	Was Decedent	of Hispanic Origin? Juban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	)- 14. R	ace - Ameri ack, White	etc.	
Maryland 21215-0036 nd 2 should be tiled within 72 hours aff atth and Mental Hygiene. 27 is marked other than "natural; or ritaumatic event, the Market Exami	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occ kind of work do DO NOT use ret	ne during most of v ired)	vorking	16b. Kind of		dustry	
aryland should be tili and Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last)  MAX		FREEDLA		IDA	lame (First, Middle		RUDO		
lore, Maryla ges 1 and 2 should tt of Health and Mer if item 27 is marke or other traumatic			ype, Print) ISTER	1 SU	NTOP CT	APT. 10		er, City or Town			
Baltimore,   permit. Pages 1 and Department of Heall Important: If item 2 eny injury or other sonce.		20a. Method of Disposition  1 X Burial 2 Cremation 3 L  1 4 Donation 5 Other (Specify,	)	20b. Place of Dispo cemetery, crer BNAI ISRA	natory or other p	· I	Date 21/2004	20c. Location BALTI			
Balt  permit. Depart Imports eny inj		21. Signature of Funeral Service Licens	ن نسر	22	. Name and Add	dress of Facility	OL LEVIN	SON & B	ROS.,	INC.	
cate be executed Executed Executed Physician and physician and street transit transit	dicai Examiner	shock, of heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, for your cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. — Ous to (or as c.	a consequence of): a consequence of):	IA	n favo	ction			Interval Bet Onset and I	Death
.O. Box ( the death certify the attending ched for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnar Other (specify)	ncy			ate of delive		<b>Yea</b> r
rdS, P. quires that an signed b		Part II. Dther significant conditions co	ntributing to death bu	ut not resulting in the ur	nderlying cause (	given in Part I.	23e. Did to	obacco use cor	itribute to th		eath? Jnknown
f VITAI RECOTGS, ysicien: The law requires to is certificate has been signe director, page 2 should be d	Completed	25 W.						rmed? 2 No	prior to cor death?	psy findings and pletion of ca	available ause of
DIVISION OT VITAI  I or Attending Physicien: 1 after death. Director: After this certificat if in by the funeral director, p	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1  lnpatie 28a. Date of Injur (Month, Day		28c. Inj	Other: 4X Nursing	eath <i>Check onl o</i> .  Home 5 \sum Resid  28d. Describe h	lence 6 🗆 Oti		<i>(</i> )	
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	iry - At home, farm, stre :. (Specify)	et, factory, office	9	28f. Location (S City or Tow	Street and Num m, State)	ber or Rura	l Route Numb	ber,
the Hospi in 24 hour he Funer. pletely fills	Medical	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best oner: On the basis of and manner sta	of my knowledge, death examination and/or inv ted.	occurred at the estigation, in my	time, date and place opinion, death occ	ce, and due to the courred at the time, of	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)	)
Tot Tot Tot		29b. Signature and title of certifier  COKEA	ney n	P	29c. Licer	0 2 7 8	60	29d. Date signe	18 m	Day, Year)	4
		30. Name and address of person who co	D. KEAK	eath (Item 23a) (Type, F	700 L	J40ths	+ BAH	. Ad	212	18	•
Sta Regist		31. Date filed (Month, Day, Year)  MAR 2 3 20	262	r's Signature	وكانت						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 09080 State Registrar AMEND ITEM #11 PER FH G829 3/23/04 Gertificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day MARCH 20, 2004 Year **Physician** 5:00 P M **FLEISCHER** /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON BALTIMORE MANOR CARE OF TOWSON 8. Date of Birth Month, Day, Year) JUNE 29,1911 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🙀 F 92 Yrs. MD 215-54-0883 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD N/A BALTIMORE Direct 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 238 7015 PARK HEIGHTS AVENUE 21215 death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: WHITE þ ₩Widowed 4 Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ot Health and Mental H I Item 27 is marked of r other treumatic ever Pages 1 and 2 should be DANOFF ANNA BESSICOV HYMAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1619 GREENSPRING DRIVE - LUTHERVILLE, MD 21093 ISRAEL MILTON FLEISCHER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) CHERNIGOVER CEMETERY! 3/22/2004 ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Well 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List entylone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMON: MIDDLE **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** MEIMER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Due to Examiner or Attending Physician: The law requires that the death certiticate be executed and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached tor in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 Probably 4 Unknown 1 □ Yes 2 □ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Beath (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Medical Certification: To 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Atter 5 Pending 1-Natural 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident hours after death 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 - Homicide within 24 hours a To the Funerel 6 29a. Certifier ₩ Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

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State Registrar

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30. Name and address of cerson who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** JOSEPH ROBERT GALLAGHER MARCH 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Saint Joseph Medical Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) MM 2 F 214-18-2162 Director 81 8/27/1922 MARYLAND Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location th and Mantal Hygiane. 27 is marked other than "netural", or Items 23e or 28e-f show traumatic event, the Medical Examinar must be nutified at 28a-f show 10d. Inside City Limits Director BALTIMORE TOWSON 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8305 - C LOCH RAVEN BLVD. 21286 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WHOLESALER 11 TH GRADE SALESMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fits Depertment of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event Be JAMES M. GALLAGHER ROSINA C. SCHAAR ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES GALLAGHER BROTHER 8301 HILLENDALE ROAD BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) NEW CATHEDRAL CEM. 3/24/2004 BALTIMORE, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. 10WSON, MD 21286 Part 1. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician UPPER GASTRIC INTESTINES HEMORRHAGE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) transit certificate be executed and burial-t Due to (or as a consequence of): the attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe CHRONIC OBSTRUCTIVE PULMONARY DISEASE Yes Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has page this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) \_2(X)No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident (Month, Day Year) 5 Pending within 24 hours after uses... To the Funeral Director: Aft investigation 1 Yes 2 No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitet 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Blanch 21, 2004 2658 MN 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) 32. egistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O. 1

of Vital Records,

Division

23 2004

LONDON MERKERNO ELEVA

State of Maryland / Department of Health and Mental Hygiene 09082 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CHARLES CALVIN GOAD MARCH 2004 8:10 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 TM 2 F 70 Director 214-32-2654 Mar PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or Items 23a or 28e-f show treumstic event, the Medical Examiner must be notified at 10d. Inside City Limits Md Carroll 1 ☐ Yes 2X ☐ No Mt. Airy Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 W. Church Street 21771 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. sont: If item 27 is marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 7 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🖁 No Baltimore, Maryland 21215-0036 Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Howard Co. Board Elementary/Secondary (0-12) College (1-4or 5+) building supervisor of Education 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Earl Bennett Goad Helen Wakefoose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daisy Goad (spouse) 107 W. Church St., Mt. Airy, MD 21771 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State Marriottsville, Md permit. Page Department of Importent: If any injury or once. Mt. View Cemetery `4 Donation 5 Dother (Specify) 3-25-04 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Dauge Haight erbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic melanoma Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the first line of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 1 No 2 No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No s after dea...rel Director: After ... 28b. Time of Injury 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred To the Hospitel or Attending 5 Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number alakas D0059283 March, 20, 2004 30. Name and address of par on who completed cause of death (Item 23a) (Type, Print) 7th Street Frederick, MD 21701 Addo M.D Offei Kichard 400 West 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 3 2004 Registrar

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ate of Maryland / Department of Health and Men	ntal Hygiene 200 L	09083
Certificate of Death	Reg. No.	

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Geller William R. MARCH 19, 2004 11:45 a /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A LEVINDALE GERIATRIC CENTER BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F 87 213-07-3635 June 24.1916 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Baltimore Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21234 2104 Cider Mill Road Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death be Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 234 eny injury or other traumetic event, the Mudical Example to the Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Clerical Worker 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Mary A. Hynek Geller William Lewis ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Cider Mill Rd., Baltimore, MD 21234 Mrs. Jean Mattson Geller (wife) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem'l Gardens 3/23/2004 Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Signature 11 meral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes ( 9705 Belair Rd., Baltimore, MD 21236 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) with complications Physician Due to (or as a consequent of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2X No certificate 1∏ Yes Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) chronic Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Care Ctr. Medical Certification: To Yes 2□ No funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Japiter L.
4 hours after dea.
real Director: After 1 Natural 5 Pending pedesman struk by vehicle 1 Yes 2 No 1:25 P M 2 Accident 3 Suicide investigation January 17,2004 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1925 E. Joppard, Britmore Loury within 24 hours To the Funeral 29a. Certifier (Crisck only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 **OCME** MARCH 20,2004 MD Theerberg 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Penn Street, Baltimore, Maryland 21201 Tasha Z Greenberz 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

MAR 2 3 2004

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** MARCH 2004 6:47 217 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Center Baltimore TOWSOR 9. Birthplece (Stete or Foreign Country)

ARYLAND If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCIDBER 26; 1926 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 12 M 2 F 216.20.246 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or itama 23a or 28a-f ahow the Medical Exactment transl by notified at 1 ☐ Yes 2 ☑ No Director MARYLAND DALTIMORE LTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2123 DRIVE 26/6 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: WW 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 end 2 should be filed within hent of Health and Mental Hygiene. int: If Itam 27 is marked other than." College (1-4or 5+) Elementary/Secondary (0-12) FOVERNMEN EDFRAL NGINEER traumatic avant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ISSNER 2 HOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2616 ARGARET or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. MARCH 24, 2004 EMETERY 4 ☐ Donation 5 ☐ Other (Specify) ARKIVOOD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee EVANS CHAPEL ROAD, PARKVILLE 2123-8800 HARFORD Feed Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea e or complications that caused shock, or heart failly e. .ist only one gause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Fina disease or condition resulting in death) ATHEROS LEROTIC CARDIOVASCULAR DISEASE YEARS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) the attending physicien Be Completed by Physiclan/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 99 3 Probably 4 □Unknown HYPERTENSION 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed? 2 No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 1 Tes 2 ER/Outpatient 3 DOA Medical Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After Hospital or Attanding 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 3/20/04 D 51852

Registrar

State

DAVID

A

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

OSLER DRIVE,

TOWSON, MARYLAND 21204

7601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRINKER

M. D.,

LEVE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 706 PM **Physician** 2004 Robert Gordon Grenell, Phd. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3900 N. Charles St., apt. 1412 Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□F 87 New York April 3, 1916 Director 218-32-8840 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Examinar research show other. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 ☐ No Directo Maryland Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3900 N. Charles St., apt 1412 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grenell Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 N. Charles St., apt 1412, Balto., MD 21218 Dena Grenell/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 3/23/04 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland Baltimore-Washington Crematory 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 21. Signaul o SyFune al Service Ligense Bryan W. Clary W. Clary 23a. Part1. Ever the disease, or complications that ca shock, or heart failure. List only one cause on ea sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate C use # inal disease or con in on resulting in death) renal failure **Physician** 4 Ear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of linear of injury that initiated events Due to (or as a consequence of): Examine The taw requires that the death certificate be executed attending physicien and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by rioscleratic cardio vascula 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ransitional cell 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Mas case referred to phodical examiner? Vascular disease 1 Yes 2 No 1 Yes To the Hospitel or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 28c. Injury at Work? 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10030717 m 20c) (Type, Print) Baltemore 30. Name address of p of death (III 670/NI Charles StSuite 5201 Cool, M.D 21204 31. Date filed (Month, Day, Year) State MAR 2 3 2004 Registrar

DHMH 17 Rev 1/2001

Registrar

MAR 2 3 2004

2004

18,

MARCH

CONSTANCE GRAZIANO

State of Maryland / Department of Health and Mental Hygiene 09087 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician**  $11:30p_{M}$ 19, Frank John Gorecki 2004 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/ABaltimore Future Care Canton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 15 M 2 ☐ F 84 Yrs. Maryland 218-01-2420 Director 3/24/1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at n/a MD Baltimore 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 USA 3507 Esther Place Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Arms. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ⊠Yes 2 □ No Army If Yes, Give WWII Year or Dates: Black White etc. filed within 72 hours after 1 Never Married 2 Marned white Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced "naturai", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Armco Steel Steel Worker 9th rages 1 and 2 should be fith nent of Health and Mental Hy nt: if item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Gorecki Eleanor Bannock 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Theresa Gorecki 3507 Esther Pl., Baltimore, Maryland 21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Sacred Heart ofJes 3/24/2004 Baltimore, MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. FH 21. Signature of Funeral Service Licensee 263 S. Conkling St.Baltimore, MD 21224 1 (asla Lannevo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition EMENTIA Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liceate of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-transit and Due to (or as a consequence of) the attending physician 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached fo P.O. I 9□ Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by page 2 should be 2 No 3 Probably 4 Unknown been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 2 No 1 ☐ Yes rector. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide õ Fo the Hospital Medical 1🗂 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4 29hs MARCH 22 ZOON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 750 r HARISACION ww COLUCY DAINE TOWICK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 3 2004

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			1 - State Registrar		ertificate of Death		eg. No. 2004	09088
			1, Decedent's Name (First, Middle, Last)	1 1	7	2. Date of Deat	th	3. Time of Death
	Physici /Medio		Hottie Mae	Leath (	aines	MARCH	17, 2004	1230 P M
1	Examir		4a. Fecility Name (If not institution, give street and no	umber)	4b. City, Town, or Location of	f Death	4c. County of Death	
			2930 OAKLEY AVENUE		BALTIMORE C		NIA	
	Funeral		5. Social Security Number 6. Sex  1 □ M 2 ØF	7. Age (In yrs. last birthday	If Under 1 Year   If Under 2	Min. 8. Date of Birth	Year) 9. Birthr	place (State or Foreign ntry)
	Director	(	X19-50-6633	56 118.		Jan, 31	,1948 Ge	orgia
	land ow		10a. State 10b. County	10c. City, Town or I	ocation		1	10d. Inside City Limits
	death with the Maryland me 23s or 28s-f show finals to traffied at	ţ	Maryland N/A	Balt	imore			1 Yes 2 ☐ No
	h the	Director	10e. Street and Number		10f. Zip Code	10	0g. Citîzen of What Cour	ntry?
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	ter death with the Marylan itame 23a or 28a-f ehow itam man by collified at	Funeral	11. Marital Status 12. Was De Armed F	cedent Ever in U.S. 13	. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	14. Race - Americ Black, White,	
36	or it		1 Never Married 2 Married 1 Tyes	2 No	1 Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: T)	. 17
21215-0036	J within 72 hours after jiene.	d by	3 Widowed 4 Divorced Year or				BU	ack
5	in 72	Completed	15. Decedent's Education (Specify only highest grade completed	) (Giv	edent's Usual Occupation e kind of work done during most DO NOT use retired)	of working	16b. Kind of Business/In	idustry
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	at the	BeC	17. Father's Name (First, Middle, Last)			's Nam <i>e (First, Middle, N</i>	Maiden Surname)	
/lar	vid be Mental irked c	To B	Warren Shaw	Leath II	Ha	Hie Ma	e Black	Shear
Maryland	2 shou and M ie mar aumati		19a, Informant's Name/Relationship (Type, Print)	(SON) 19b. Mai	ing Address (Street and Number	r or Rural Route Number,	City or Town, State, Zip	Code) 19382
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Ore	0 = 0		20a. Method of Disposition / 1   Burial 2 □ Cremation 3 □ Removal from	20b. Place of Disp cemetery, co	osition (Name of amatory or other place)	Date 2	20c. Location - City or To	wn, State
altimore	Departmen Departmen Mportant: Iny injury		'4 □Donation 5 □Other (Specify)	Lorra	ne Parki	193/2004	Balto. 1	VId.
Bal	permit. Pa Departmen Important any injury		21. Signature of Funeral Service Licensee	Quant 5	22. Name and Address of Facility	s Funeral	1 Home.	262
		_	23a. Part. Enter the disease, or complications that	caused the death. Do not el	222 W. North	AUR. B	alto. Md.	Approximate
			shock, or heart fallure. List only one cause on Immediate Cause (Final	each line.	to the mode of dying, sach as t	ardiae or respiratory arre	751,	Interval Between Onset and Death
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N	Examiner			(or as a consequence or).				
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8760	2 2 2	Physician/Medical	d					
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Вох	atten for us	ian	in the past 12 months?	birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
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Vital Records,		Be C	25. Was case referred to medical examiner?		26. Place	of Death (Check only one	<b>\</b>	22.10
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isio	Attending r death. ector: After y the funer	icati	2 Accident investigation 3 Suicide 6 Could not be 380 Place	a of Injury. At home form	M 1 Yes 2 N			10. 1. 1.
Division	l or A	Certification;	determined 200. Flac	e of Injury - At home, farm, s ling, etc. (Specify)	reet, ractory, office	City or Town,	reet and Number or Rura , State)	ar Houte Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	aiC	29a. Certifier 1 Certifying Physician: To th	e best of my knowledge, dea	th occurred at the time, date and	place, and due to the ca	use(s) and manner as sf	tated.
	ne Ho ne Fui	edicai	(Check only 20 Medical Examiner: On the	pasis of examination and/or inner stated.	nvestigation, in my opinion, death	occurred at the time, da	ite and place, and due to	the cause(s)
	To the To the Comp	Ň	29b. Signature and title of certifier	· DM	29c. License number	!	d. Date signed (Month,	
)	./	l is	Hatrin Wion	10/10	OCME	I	MARCH 18, 2	004
	h		10. Name and address of person who completed page	11 11 -	·			
			RYKICIA XIONICA-TI		Penn Street, Ba	ltimore, Ma	ryland 2120	1
	Sta Registr			egisfrar's Signature	0			
DH	MH 17 Rev 1/2	-	MAR 2 3 2004	Ever A A	2000			
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			State of Maryland / Department of Health and  1- State of Maryland / Department of Health and Registra AMEND ITEM #10c PER FH G829 3/25/04 Gentificate of Death		jiene 	กจกลจ
			1 Decedent's Name (First, Middle, Last)	2. Date of Dea	103/21/200/4 <sub>ear</sub>	3. Time of Death
	Physicia /Medic		DONALD R HILLMAN	Bet	-28 -1937	- 2.15 PM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat  4c. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat  4c. City Town, or Location of Deat	th	4c. County of Deat	
			5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth		nplace (State or Foreign untry)
	Funeral Director		023-28-0288 1 M 2 F 66 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day Oct. 28	, $\frac{Co}{1937}$ Mass	achusetts
	p .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Aanyla r show	ō	MD Howard Columbia ELLICOTT CITY			1 □ Yes 2 ▼No
	r 28e-	Director	10e. Street and Number 10f. Zip Code		l0g. Citizen of What Co	untry?
	th with	alD	7655 Stony Creek Lane 21043		USA	
	r dee	Jue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (See Specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	by F	1 □ Never Married 2 ◯ Married 1 ◯ 📉 Yes 2 □ No If Yes, Give 1 □ Yes 2 ◯ X No Specify: Year or Dates:		Specify: V	hite
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23s or 28s-f show any injury or other treumatic event, Its Medical Examinat must be notified at ODGs.	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wo	orkina	16b. Kind of Business/	Industry
21	ithin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		-	
121	Hygier Hygier Iher th	S	12 2 Realtor  17. Father's Name (First, Middle, Last) 18. Mother's Na	me (First, Middle,	Real Est	ate
and	d be f ental l ked ol	To Be		Towne		
ary	shou and M s mar	-	19a, Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or R	ural Route Numbe	r, City or Town, State, Z	(ip Code)
	and 2 ealth in 27 I		Shirley Hillman - wife 7655 Stony Creek Lane			
ore	t of H t of H if Iter or oth		20a. Method of Disposition  1 🛱 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or	
Baltimore,	it. Pa urtmen ortant: njury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licensee</li> <li>22. Name and Address of Facility</li> </ul>	24/04	Elkridge, M	110
Ba	Depa Impo any i		Mgx. Hukman Fun 7250 Washington Blv	neral Hom	e at Meadowr	idge MP, Inc.
20	4 1		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ic or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition SEVENE CARD 13 170 PASH 7			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):  Con ( Es Tine Internet Farwice  Sequentially list conditions			
*	<b>1</b>	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease or injury			
	cuted	Examiner	that initiated events		_	
,092	be execulicien and burial-trai		resulting in death) Last  Due to (or as a consequence of):  HTPENIENMON			
6876	y s	dical	d			
Box (	the death certifica y the attending ph iched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del	
	ne death the atte	sicia	in the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ds,	uires tha signed Id be del	d by	STROKE	1 🗆 Y	es 2 No 3 Pr	obably 4 Dunknown
of Vital Records,	The law requires that ate has been signed b page 2 should be deta	Completed	CORONARY ARTERY DISEASE PERICHERAL VALUETA DISEASE	24a. Was a	an 24b. Were au	topsy findings available completion of cause of
I Re		Com	PERICHERAL VACULAR BYEAST	perfor	med? death?	4.004.00
/ita	Physician: The this certificate ral director, pag	Be	examiner?	eath (Check only or		
of	Phys	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ence 6 Other (Spec ow injury occurred	cify)
ion	ittending P death. ctor: After I y the funera	ation	1			
Division	after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or Run, State)	ıral Route Number,
	To the Hospitel or Atter within 24 hours after de To the Funerel Directo completely filled in by th		Co-Continue 17/Continue Shusiana To the heat of my keepyledge, death accurred at the time, date and place	o and due to the s	anuacia) and manage as	atatad
	24 hos	edical	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plac (Check only one)			
	within To the compl	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mont	
)			ATTENDING PHYTHIAM DOD STEFF8		MARCH 2	2 2004
	Ax,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TANSON DA HOWARD COVNY SENSI  31. Date filed (Month, Day, Year)  MAR 2 3 2004	nai Ho	SPITAL	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			Ŧ.
			MICH & A -			

		1 - For State Registrar	State of Ma	aryland / [		artmen rtificat					Reg. No.	200	
Physic /Med	ical	Decedent's Name (First, Middle, L     CELESTE P. HARV     4a. Facility Name (If not institution, g	/EY			4h City	Town or	Location of	]1	2. Date of De Month MARCH	Day 19		10:00 P.
Exami Funeral Director		907 SHELLEY ROAL		e (In yrs. last bii	rthday) Yrs.	If Under Months	TOWS			8. Date of Birt (Month, Da 4/19/	th y, Year)	BALTIMO	
υ		Usual Residence of Decedent  10a. State 10b. County  MD BALTIMO	DRE	10c. City, Tow		ocation					.,,,,,,		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
With the Page or 28a-	Funeral Director	10e. Street and Number 907 SHELLEY ROAI	)			10f. Zip	Code 2128	6			-	zen of What C	Country?
I ey, INIAI y IAIILU KIKI ISTOOSO s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Meniai Hygiene flem 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at	þ	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 It Il Yes, Give Year or Dates:			Was Dece II Yes, spe 1 ☐ Yes		spanic Orig n, Mexican, Specify:	in? (Spec Puerto P	cify Yes or No lican, etc.)		14. Place - An Black, Wh Specify:	nerican Indian, hite, etc. WHITE
filed within 72 ho Hygiene. Other than "naturent, the Medical	Completed	15. Decedent's (Specify only highest (Specif	Education trade completed) College (1-4or 5		(Give life.	dent's Usua kind of wo DO NOT u ECRET	rk done a se retired,	lu <i>ri</i> na most	of workin	g		nd of Busines	s/Industry
Z should be file and Menta! Hy is marked othe sumatic event,	To Be C	17. Father's Name (First, Middle, La FREDERICK PATZ)  19a. Informant's Name/Relationship	SCHKE	198	b. Mailir	ng Address	(Street a	MAR	GARE'	(First, Middle,  C KREBS  Route Number	5		, Zip Code)
tges 1 and 2 sold feet trans		JOHN W. HARVEY  20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Place o	of Dispo	matory`or o	ne of ther place	a)	Da	ON, MD		cation - City o	or Town, State
permit. Pages Department of the important: If its any injury or o		*4 □ Donation 5 □ Other (Special Service Lice	ensee	PARKW	8	2. Name ar 5≈1 L	od Addres	s of Facility	THE BLVI	O. TOWS	ON FU		HOME, P.A. 1286
Physician /Medica Examiner price and price	Examiner	23a Part. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a consequence	of):	Or the moo	ne of dying	g, such as d	cardiac or	respiratory ai	rrest,		Approximate Interval Between Onset and Death  444733m4
COTCS, F.O. DOX DO (DO), w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Û No 9 □ Unknown	d	2 Fetal death		⊒Ectopicp ⊒ Other (s <sub>i</sub>						23d. Date of d Month	lelivery Day Year
ords, requires that	by	Part II. Other significant conditions	s contributing to death b	ut not resulting	in the u	inderlying o	ause give	en in Part I.					to the cause of death? Probably 4 뗉Unknown
The lay ate has page 2	e Completed	25. Was case relerred to medical						CC Plans	of Dooth		osy ormed? 2 No	prior to death?	autopsy findings available completion of cause of es 2 No
Phy Phy of	To B	examiner?  1 Yes 2 No  27. Manner ol Death  1 Natural 5 Pending 2 Accident investigat	Hospital: 1  Inpatie  28a. Date of Inju (Month, Da		Time o		28c. Injury Work	er: 4 ☐ Nur	rsing Hom	ne 5 ABesid 8d. Describe	dence (		pecify)
	Certification:	3 ☐ Suicide 6 ☐ Could no determine	building, et	c. (Specify)						City or Tox	wn, State	)	Rural Route Number,
To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	Medical		Physician: To the best aminer: On the basis o and manner st	f examination a		vestigation	c. License	pinion, deati	h occurre	d at the time,	date and	place, and di	
50 V		30 Name and address of person with the control of t	no completed cause of c	death (Item 23a)	(Туре,	Print	416	369 i	4) R1	ALT.	3/3 MX	0 Z1	204
S Regis	tate trar	31. Date liled (Month, Day, Year) MAR 2 3 20	40	rar's Signature	And	A 60 B	-		_1/1				

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			For State	State of Maryla		artment of H			CUU4	09091
			Registrar  1. Decedent's Name (First, Middle, Last,			rimouto or i	Douth	Reg. I	10.	3. Time of Death
	Physicia	an	THOMAS S		HART	NEV		Marth a	Day Year	11:31 A M.
	/Medic Examin		4a. Facility Name (If not institution, give		0 (1-11-(1)		r Location of Death		c. County of Death	1131
	Examili	eı	8621 Richmon	1140:70		Park	ALL	C	ALTimo	RI
-	Funeral		<ol><li>Social Security Number 6. Set</li></ol>		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	91111	lace (State or Foreign
	Director		316 32 1800	M 2 F BT	Yrs.	Months Days	Hours Min.	MAYING	36 MAG	27.400
	pu ,		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Le	ncation				Od. Inside City Limits
	anyla shov	5			<u> </u>	~				1 ☐ Yes 2 No
	the M	Director	10e. Street and Number	082	MARK	10f. Zip Code		100	Citizen of What Cour	atov?
	with e or i	늅	0.	~ N° 0-1.		101. Zip 000e		109.	1) 1	itry :
	eath	eral	8631 Kichmon	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of H	lispanic Origin? (Spe	ecify Yes or No-	14. Race - Americ	can Indian,
′0	r Iten	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
93	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: WH	311)
21215-0036	within 72 hours after death with the Maryland one. than "natural", or items 23e or 28a-f show the M. Jical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occup	during most of works	ing 16b.	Kind of Business/In	dustry
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12	o filed within al Hygiene. I other than "want, I're M.		17. Father's Name (First, Middle, Last)		1.V-	IICHI	18 Mother's Name	(First, Middle, Maid		13665
Maryland		Be	-: 0 110	(1)			10. Mother's Haine	mail V	- C	
ž	should nd Men marke umatic	은	19a. Informant's Name/Relationship (T)	ACCIOS	19h Maili	ng Address (Street	and Number or Bure	I Route Number, Cit	vor Town State Zin	Code a 234
Ma	d 2 should be sh		MARY A- HART	3 . 1	8731	BUHM	100 100	1089 -19	7 211.50	000 Mad
ē,	s 1 and 2 of Health itam 27		20a. Method of Disposition		b. Place of Disp	osition (Name of	IOUT FIF	Date 20c.	Location - City o To	own, State
JO L	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	temoval from State	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	matory or other place			elisiyo	Cherland
altimore,		e Vi	21. Sinn the Funeral Service Licens		2	2. Name and Addre	4 Cille-		1141112	ARSA
ä	permit. Departr Imports any inj		The thorn	1		14 00 B	8F528F	ENGGEL	KVILLE	JERVILAGO
			23a. Part1. Enter the disease, or complished, or heart failure. List only of	ications that caused the c			ng, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Ény <b>sicia</b> n		Immediate Cause (Final disease or condition	motas	1 1	9	renem			Onset and Death
	/Medical		resulting in death)	Due to (or as a con		ary cu	10 021-011-			
	Examiner		Sequentially list conditions,	b		U				
	p ii	iner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	secuence off:					
	and and -trans	Examin	that initiated events resulting in death) Last	c. Due to (or as a con	coguando of):				-	
60,	cate be executed physician and the burial-transit		, , , , , , , , , , , , , , , , , , , ,	Due to (or as a con	sequence on).					
98760	icate be executed physician and s the burial-transit	dicai		d						
9 x	death certifica e attending ph ad for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of delive	ery
Вох	atter 1 for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time		□Ectopic pregnancy □ Other (specify) _	/		Month	Day Year
0	the c by the ached	hysi	9 Unknown	9□ Unknown						
Р,	w requires that been signed t should be deta	by P	Part II. Other significant conditions co	ntributing to death but not	resulting in the t	underlying cause giv	ren in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
Records,	requires leen sign hould be							1 🗆 Yes	2 □ No 3 □ Prob	ably 4 Unknown
000	law re as bee 2 sho	plet						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
R	e Lie	Completed						performed	death?	
Vital		BeC	25. Was case referred to medical				26. Place of Deatl	(Check only one)		
f V	g .g	ToE	examiner? 1 🗌 Yes 🐉 No	Hospital: 1 Inpatient	2 ☐ ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing Ho	me 5 Residence	6 □Other (Specif	y)
n of			27. Manner of Death  ↑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wor	rk?	28d. Describe how in	jury occurred	
Sio	Attending ir death. actor: After by the fune	catio	2 Accident investigation				Yes 2 □ No			
Division	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st necify)	reet, factory, office		28f. Location (Street City or Town, St		I Route Number,
	urs al		an Carlina Bhu	risis - V H - b - b - f		Maria de la Maria			(-)	
1	Hosp 24 ho Fune Fune	edical	29a. Certifier	sician: To the best of my iner: On the basis of exame and manner stated.	nination and/or in	th occurred at the tir rivestigation, in my o	me, date and place, ppinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as s and place, and due to	tated. the cause(s)
	To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	Mec	29b. Signature and title of certifier	and marinor stated.		29c. Licens	se number	29d. l	Date signed (Month,	Day, Year)
)	- s - ō		Marrie Kenn	alud.	110	A a	21022	3	EE HIDDA	20011
	12		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type	, Print)	. 100.	1 16	DE MODIFIE	0004
	1		DR MARiON	Kowalsi	us.Ki	1612 Bu	11022 LRIRR	780		
	Sta	ite	31. Date file A Porh. Qay, Year	32. Registrar's S	ignature					
	Regist	rar		parties Al	A 1000					

RKD

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Registrar  1. Decedent's Name (First, Middle, La	State of Maryland \$23a&27 per me	erti	ticate of L	Death	2. Date of Dear			0 9 0 9 3. Time of Death
Physici			Frank Herben	ar			Month MARCH	Day 16,	$20\overset{Year}{04}$	2007 P.
/Medic Examir		4a. Facility Name (If not institution, giv SINAI HOSPITAL	e street and number)			Location of Death	h	4c. Cou	inty of Death	
Funeral Director		3/2-14-3/39	MA 2DE		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	, Year) 191	9. Birthp Cour 4 Mic	place (State or Fore http:) Chigan
-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland N	/ A 10c. City	Town or Loca	tion timore	-				I0d. Inside City Lim <b>X</b> ∑Yes 2 ☐
Se or 28a	Director	10e. Street and Number 1206 Sabina Av	enue		10f. Zip Code	21209	1	0g. Citizen	of What Cou	•
of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23s or 28s-f show item 27 is marked other than "natural Ecrivitiled at other traumatic event, the Medical Evantiest must be rivitiled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Vidowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? TXOX'es 2 □ No WW If Yes, Give Year or Dates: + Kor	III ,	as Decedent of Hi es, specify Cuba	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		Race - Americ Black, White, ecify:	
iene. than "natur ne Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give ki	NOT use retired	during most of wor )	rking		f Business/In	dustry
iental Hygiene. Ked other than " ic event, Ira Me	To Be Cor	12 17. Father's Name (First, Middle, Last Joseph Herbena		Pny	sical i		ne (First, Middle, I y Klimk	Maiden Sun	army	
eaith and Mental n 27 is marked o		19a. Informant's Name/Relationship ( Steven Herbena	• • • • • • • • • • • • • • • • • • • •	1		and Number or Ru . Avenue	ural Route Number e Balt:			Code) 21209
nent of Health int: If item 27 iry or other tr		20a. Method of Disposition  1  Burial 2XX cremation 3   4  Donation 5 Other (Special	Removal from State		tory or other plac	ngton :			on - City or To	own, State
Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice		B <sup>22.</sup>	Name and Addres	s of Facility nss-Se:	itz Fund Baltii	eral	Home,	Inc
nysician and make prize transit the prize transit tran	al Examiner	disease or condition resulting in death)  Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)  Cue to (or as a consequence)  Due to (or as a consequence)	rence of):	ilitis					
as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	_d. 23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 E	ctopic pregnancy Other (specify)			23d.	Date of delive	ery Day Year
n signed b	by	Part II. Other significant conditions	contributing to death but not resu	ilting in the und	lerlying cause give	en in Part I.		_	contribute to t	he cause of death? pably 4 AUnkno
ate h page	Completed					3-1-2	24a. Was a autops perform	med?	prior to co death?	opsy findings availa impletion of cause of 2 No
this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 🛣	ER/Outpatient	3□ DOA Othe	00	ath <i>Check only on</i> Home 5 \( \subseteq \text{Reside}		Othor (Special	541
r death. ector: After this by the funeral di	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work		28d. Describe ho			y)
after de Directo in by th	Certification:	3 Suicide 6 Could not be determined			et, factory, office		28f. Location (SI City or Town		ımber or Rura	al Route Number,
S = 00			nysician: To the bast of my kno- miner: On the basis of examinal and manner stated.							
in 24 hours a	edical				1		1 0	Od Data at		Oay Vaarl
Within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medic	29b. Signature and title of certifier	` <u> </u>		29c. License	.C.M.E.			gned <i>(Month,</i> L <b>7 ,</b> 2004	

DHMH 17 Rev 1/2001

ORIGINAL

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partment of Health and	Mental	Hygiene	0	1
partment of Health and ertificate of Death			U	l

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Kurm, as James HAMILTOH	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Denartment of Health and Mental Hvoisne
		Phy /M Exa
sh.	Box 68760,	eath certificate be executed

Ba	permi Depar Impor any ir
Page:	Physician /Medical Examiner
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
	N/

		State Registrer			Certifica	ite of Dea	ath	Re	g. No. U () 4	09093
Dhysinic		1. Decedent's Name (First, Middle, Last)	. 1	4. 2	-	1		2. Date of Death		3. Time of Death
Physicia /Medic		JAMES	HENRY	HAI	MIL	TON	JR.	March	Day Year	+ 12:209 M
Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. Cit	y, Town, or Local	tion of Death	V	4c. County of De	ath
			of bathine	ne		althu	ore (	ety	N	14
Funeral Director		717-60-6132	7. Age (In	yrs. last birth	Month		urs Min.	Date of Birth (Month, Day,	Year)	rthplace (State or Foreign Country)
and w		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town o	or Location				7	10d Inside City Limite
aho ed el	ō	101 011 110		o. ony, rount	or Education	2		1		10d. Inside City Limits 1 28 es 2 □ No
the N	Director	10e. Street and Number	14		1101	DALI	11101	EC	( T Y	
with a or	급	11.5 A D C	0 1	2-10	10f. 2	Zip Code		10	g. Citizen of What C	country?
eath	erai	4028 FAI	2. Was Decedent Ever	KOAD	10 W - D-		121	6	u.	54,
is after death with the Marylan , or Items 23s or 28e-1 show Gminer must be notified at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1	Armed Forces?  1 Tyes 2 No	in 0.5.	If Yes, sp	edent of Hispanio ecify Cuban, Me	xican, Puerto Ri	ity Yes or No- ican, etc.)	14. Race - Am Black, Wh	
urs af	by F	3 ☐ Widowed 4 Ž Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	22No Spe	ecify:		Specify: 12	1 2011
filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Items 23a or 28e-1 ahow ant, the Medical Examinar must be notified at	Completed	15. Decedent's Educ		16a. D	ecedent's Us	ual Occupation		1	6b. Kind of Busines	s/Industry
be filed within 72 ho ital Hygiene, id other than "natu event, Ire Madical	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		ive kina ot v ie. DO NOT	vork done during use retired)	most of working	7		
or th	Con	12 HIGRADE	,	TRI	ACTOR	ZTRAIL	ER DI	RIVER	G.O.	Δ.
be filled that the standard of	Be	17. Father's Name (First, Middle, Last)				18. M	Nother's Name (	First, Middle, M	aiden Sumame)	1
2 should be filed within and Mental Hygiene.  Is marked other than sumatic event, Ite M.	٩	JAMES HE	NRV F	TAMI	LTOI	USR. E	- 4121	7 BETI	4 M	ARTIN
2 sh and le m		19a. Informant's Name/Relationship (Typ	e, Print)	19b. N	failing Addre	ss (Street and Nu	umber or Rural i	Route Number,	City or Town, State,	Zip Code)
s 1 and 2 should f Health and Mer item 27 le marke other traumatic		LENA PORTER	SISTER	) 2	4 Wy	ECATE		WING	S MILLS	40.21117
Pages 1 nent of H nnt: If ite ury or ot		20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □ Re	1		crematory or	other place)	/ Dai	4 4 11	Oc. Location - City o	Town, State
t. Pa tmen tent: njury		*4 □ Donation 5 □ Other (Specify)	F	BAKER'S!	GROVELE	APT CHURC	H 03-20	6-04 1	VINCENT	-ALABAMI
permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other		21. Signature of Euneral Service License	11. W.	sins	22. Name	and Address of F	H. BR	gan		ERAL Home
		23a. Part1. Enter the disease, or complic	ations that sowed the	door Door	219	TO'N.	-ULTO,			40.21217
I 11	ļ	shock, or neart failure. List only one	cause on each line.	ueam. Do not	enter the mo	ade of dying, such	n as cardiac or i	respiratory arres	it,	Approximate Interval Between Onset and Death
Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	thd-9	tag	2 Lu	mg (	Canc	er		5 mouths
Examiner			Due to (or as a cor	rsequence (*)	:	a				
	-0	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	sequence of)						
and I-transit	ir.	cause. Enter Underlying Cause (Disease or injury		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
execution and in and ial-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cor	nsequence of):	:					
e be ex										
certificate be iding physicia ise as the bur	/Medicai									
	-	IF FEMALE: 23b. Was decedent pregnant   23	c. If yes, outcome of pro		. □ r · ·				23d. Date of de	livery
The law requires that the death attensite has been signed by the attenbage 2 should be detached for u	Physiciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ 4 Pregnant at time		3 ☐Ectopic   5 ☐ Other (s				Month	Day Year
at the by th	hys.	9 🗌 Unknown	9□ Unknown							
es tha	by	Part II. Other significant conditions cont	ributing to death but not	t resulting in th	e underlying	cause given in P	art I.	23e. Did toba	cco use contribute t	the cause of death?
equir sen s	ted							1 Yes	2 □ No 3 □ P	robably 4 Unknown
law las be	pie							24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	Completed							performe	d? death?	2000
ysician: The law is certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?					lace of Death (0	Check only one)		
Physi this o	၉	1 103 20 110		2 ER/Outpa					ce 6 □Other (Spe	cify)
Jing F	lo	27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	z8b. Tim Inju		28c. Injury at Work?		d. Describe how	injury occurred	
death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home form	M etropt (a rte	1 🗌 Yes 2		Lantin /Ctra	at and Number of S	10
after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)	, 511991, 1200	гу, опісе	201	City or Town,	et and Number or R State)	urai Houte Number,
spita nours neral		29a. Certifier 1X Certifying Physi	cian: To the best of my	knowledge, d	eath occurre	d at the time, date	e and place, and	d due to the cau	se(s) and manner as	stated
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edicai	(Check only 2 Medical Examination)	er: On the basis of exam and manner stated.	nination and/o	r investigatio	n, in my opinion,	death occurred	at the time, date	and place, and due	to the cause(s)
To the To the Comp	Ž	29b. Signature and title of certifier	0 0	9 , 1	29	c. License numb	per	290	. Date signed (Mont	
		· Jahriela	trales ,	MI		RES-	-000	> 0	earch,	18,2004
X			pleted cause of death		pe Print)	1 11 0	-1-			
0		31. Date filed (Month, Day, Year)	ZABO, M		> id La	n 405.	PITA	0+1	SAZTIA	40R€
Stat Registra		MAR 2 9 2004	32. Begistrar's S	ignature	A w					

				State of M	arylan		-	tment of I <i>ficate of</i>	Health and Death	Mental H	ygien Bea N	e 20	04 (	191191	ı
	Physici /Medic		1. Decedent's Nama (First, Middle, La	st)	Ar	V 2	7	1		2. Date of D Month	eath D	еу		Time of Death	-
	Examin  Funeral  Director		4a Facility Name (# not institution, gine    DR ES    5. Social Security Number    233 — 07 — 08344  Usual Residence of Decedent	HAVE	ye (In yrs. I			If Under 1 Year Wonths Days		VILLE 8. Date of B	2 6	c. County	of Death TimeRE	State or Foreign	7
	farylend	'n	10a. State 10b. County Maryland Baltir	more	10c. City Cato			tion		•				nside City Limits □ Yas 2 🛱 No	
	with the A 3a or 28a-	Funeral Director	10e. Street and Number 701 Edmondson Avenue		1			10f. Zip Code 21228			10g. C	Citizan of V USA	What Country?		-
020	72 hours after death with the Marylend naturel', or thems 23a or 28a-f show dical Examiner must be motified at	by Funera	11. Marital Status  1 Nevar Married 2 Married  3 N Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates:		S.		s Decedent of es, specify Cub Yes 2 No	Hispanic Origin? ( pan, Mexican, Pue Specify:	Specify Yes or Note Rican, etc.)	lo-		e - American Inck, White, atc.  White	dian,	
5-0	n 72 ho natur	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a.	Deceder	nt's Usual Occu	pation during most of wo	nrking	16b.	Kind of Bu	usinass/Industry	'	
212	d within giene. r than r	Completed by	Elementary/Secondary (0-12) UNKNOWN	College (1-4or	5+)		known		90)		Uı	nknowr	1		
and	uld be filed with fental Hygiene. 'ked other than ilc event, the M	Be	17. Father's Name (First, Middle, Last Benjamin Jeffrey	)						me (First, Middle Courtne	e, Maide	en Surnam	ne)		
ary!	d 2 should In and Men 7 le marketreumatic	ဥ	19a. Informant's Name/Relationship (	Type, Print)		19b.	Mailing	Address (Stree	t and Number or F	- n	ber, City	or Town,	Stete, Zip Code	9)	-
Ž,	and 2 ealth a n 27 le		Leonard J. Ruck	Inc./Fun. Di					nd Baltimo		*				
Baltimore, Maryland 21215-0020	ages 1 ent of He nt: if Iten y or oth		20a. Method of Disposition 1 □ ABurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	y)	Dula	emeten aney	Vall	_	ial Gardens	Date 3-24-04			city or Town, s n Marylan		
Ball	permit. Pa Departmen Important: eny injury pnce.		21. Signature of Funeral Service Lice	2.16/1	4		530	nard J. Harford	Road Inc		-	nd 21	214		
			23a. Part1. Entar the disease, or com- shock, or haart failure. List only	plications that cause one cause on each li	the death	. Do n	ot enter	the mode of dyi	ing, such as cardia	c or raspiratory	arrest,		App Inter	roximate val Between et and Death	
8	Physician /Medical Examiner	er	Immediata Cause (Final disease or condition rasulting in death)	· Ather	Due to (or				die va.	a,/An	D	sea			_
68760,	ificate be executed g physicien and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or										_
Box 6	daath certific e attanding p ed for usa as		·	d											
P.0.	tha d by the ached	y Physician/M	Part II. Other significant conditions of Bread Ca		ut not resu	ilting in	the und	erlying cause gi	ven in Part I.		tobacc		ntribute to the 3 ☐ Probably	cause of death	
of Vital Records,	law requiras thet as been signed b 2 should be dat	Completed by	Emplyser	n9						24a. Wa	s en aut formed?	opsy	available	topsy findings o prior to ion of cause ?	
E E	The ata h		/							- 12	Yae j	250110	1 ☐ Yes	2□ No	
ZE Z	Physician: The this certificata ral director, pag	Be C	25. Was case referred to medical examiner?  1 ☐ Yes 2 → No	Hospital:	ent 2 🗆 1	EDIO. 4		all post Of	hor .	ath (Check only		a □0#	(01)		
9	p Physe er this eral di	n: To	27. Manner of Death	28a. Date of Inju	iry	28b. T	_	3□ DOA 28c. Inju		Home 5 Res					
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Certification:	Dela Naturat Calcident Cal	n e Blace of Inc	ury - At ho	me, far		M 1	]Yes 2□No	28f. Location City or To			er or Rural Rou	te Number,	_
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) Certifying Pt	ysician: To the best niner: On the basis o and manner st	examinati	vledge, ion and	death o Vor inves	ocurred et the ti stigation, in my o	ime, date and plac opinion, death occ	e, and due to the urred et the time	e cause( e, date er	s) and ma	unner as stated. and due to the o	cause(s)	_
b	To the within To the compl	Me	29b. Signature and title of certifier	2600	_			29c. Licen	se number	22	29d. D	ate signed	d (Month, Day,	Year)	
	/		30. Neme and address of person who	completed cause of c	leath (Item	23a) (	Type, Pri	int) Stop	ed Rei	sters	Lou	レワ	2/1=	36	
	Sta Registr		31. Data filed (Month, Day, Year)	32. Registr			1								
DH	MH 16 Rev 6/9			Part of the	w.A	-	2								-

			1 - For State Registrar	State of	Marylan	d / Depa	artmen rtificat	t of H	ealth a	and M		-	104	09095	
	Physici	an	Decedent's Name (First, Middle, I  RFRI	.ast) ECCA			HARRI	ς			2. Date of De	21,200	∆ <sup>Year</sup>	3. Time of Death 11:15 AM	
je.	/Medic Examir		4a. Facility Name (If not institution, g		er)		4b. City, Town, or Location of Death					4c. County of Death			
			NORTH OAKS HEAD				PIKESVILLE						BALTIMORE		
	Funeral Director		5. Social Security Number 6. 219~30-0265	Sex 7. 1 M 2 M F	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	8. Date of Bir JAN. 14	1 <sup>th</sup> 1 <sup>7</sup> 907	9. Birthp Cour	place (State or Foreign atry) MD	
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	noation						1,	Ord Institute City Limite	
	Maryla f sho	tor		ΓIMORE	Toc. City		SVILL	F						0d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	or 28a	Director	10e. Street and Number				10f. Zip					10g. Citizen of	What Cour		
	s 23a	rai	725 MT. WILSO	· T · · · · · · · · · · · · · · · · · ·					2120				U.S.A.		
920	72 hours after deeth with the Maryland natural', or items 23a or 28a-f show coal Executive I be mailling at	by Funeral	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decede Armed Force 1	as? [X]No	1	Was Deced If Yes, spec 1 ☐ Yes :		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	Speci	ce - Americ ack, White,		
5-0	72 hours natural',	eted	15. Decedent's (Specify only highest g			16a. Decei (Give	dent's Usua kind of wor DO NOT us	l Occupa rk done d	tion uring most	t of worki	ing	16b. Kind of E	Business/In	dustry	
121	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		<i>DO NOT</i> us HER/D					EDUCAT	ION/F	NTERTAINER	
nd 2	be filed tal Hygid d other event,	BeC	17. Father's Name (First, Middle, La	st)	- '					r's Name	(First, Middle,	Maiden Surna		THE THE THE	
Maryland 21215-0036		70	NATHAN	<b></b>		HARR			SAR					HOFFMAN	
	12 ha 7 is		19a. Informant's Name/Relationship DAVID HARRIS / I									or, City or Town		Code)	
Baltimore,	ges 1 and it of Healt If item 2 or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□ Bemayal from Sta		ace of Dispo	sition (Nan	ne of			ate	20c. Location		wn, State	
ij	Pa men ant: ury		*4 ☐ Donation 5 ☐ Other (Spec	cify)	LUE	BAWITZ					2004		DALE,		
Bal	permit. Departitmportit		21. Signature of Funeral Service Lic	Zen		8		EIST	ERSTO	WN F	ROAD - I		-	MD 21208	
J			23a. Pant. Enjor the disease, of co shock, or heart failure. List on Immediate Cause (Final	mplications that cau ly one cause on eac	sed the death h line.	. Do not ent	er the mode	e of dying	, such as	cardiac c	r respiratory a	rest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or	as a consequ	ience of):							-	1 week	
	Examiner	۰	Sequentially list conditions,	b											
	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) that initiated events	Due to (or	as a consequ	ience or):									
0,	cate be executed obysicien and the burial-transit		resulting in death) Last	Due to (or	as a consequ	ence of):									
8760,	cate b physic the b	dicai		d											
O. Box 6	he death certifica the attending ph thed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		2 ☐ Fetal t at time of de	death 3□	Ectopic pre Other (spe						ate of delive	ry Day Year	
rds, P.O.	luires that the de n signed by the ild be detached	by	Part II. Other six ifficant conditions	. 1	h but not resu	ing in the ur		use give	n in art I.	-	23e. Did to			e cause of death?	
Records,	The law requires ate has been sign page 2 should be	Completed										rmed?	Were autopprior to condeath?	osy findings available apletion of cause of	
/ital		BeC	25. Was case referred to medical examiner?	Manital					,	of Death	(Check only o		163	20110	
of	Physic rthis and din	1: To	1 Yes 2 No 27. Manne of Death	Hospital: 1 ☐ Inpa	njury	ER/Outpatien 28b. Time of		A Other	4 Mur			lence 6 Oth		)	
ion	Attending I r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	on (Month,	Day Year)	Injury	М	Work?	?" es 2 □ N		.00. 50001100 1	ow many occur	100		
Division of Vital	To the Hospitel or Attending Physician: Within 24 hours after death.  To the Funerel Director After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 280. Place of	Injury - At hor etc. (Specify)	me, farm, stre	et, factory,	office		2	28f. Location (S City or Tox	Street and Numb m, State)	per or Rural	Route Number,	
	spitel		29a. Certifier 1 Certifying F	Physician: To the be	st of my know	vledge, death	occurred a	at the time	a. date and	l place, a	and due to the	cause(s) and ma	anner as st	ated	
	the Ho iin 24 h the Fu	ledical	(Check only 2 Medical Exp	aminer: On the basis and manner	s of examinati	on and/or inv	estigation.	in my opi	nion, deat	h occurre	ed at the time,	date and place,	and due to	the cause(s)	
	To T com	Σ	29b. Signature and title of certifier	· ~			29c.	License				29d. Date signe	d (Month, D	Day, Year)	
	15		30. Name a radioess of person who	-		23a) (Type	Print)	73	867	)		7/1	157		
			JOEL MEGHU	yn 301	57 1	AUL S		ITE	605	BAC	TIMOR	e m	21	202	
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 3 2		strar's Signati		W.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19 2004 HUGHES March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2□ F Days Hours 64-0571 MAR Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits VYes 2 No MARYLAND 10e. Street and Number of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 22No 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OTTGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES NORMA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 DARBARA WILLIAMS (EX-WIFE STOCKTON 20a. Method of Disposition Date 1 Surial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ARBUTUS CEMETERY 03-27 22. Name and Address of Facility BROKUN JR. FUNERA 2145 PH HUBROKUN AVE., BALTO, 1 21. Signature of Funeral Service Licers 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MyoLardia uninown Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed 1∐ Yes 2 🗹 No 26. Place of Death (Check only one) Other: 2 ER/Outpatient 1 🗌 Inpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work?

**Examiner** Division of Vital Records, P.O. Box 68760 After this certificate has within 24 hours after death To the Funeral Director: . completely filled in by the t

Examiner the attending physician a hed for use as the burial-Physiclan/Medical Be Completed

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

or 28a-f show

ŏ

"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than 'any righty or other traumatic event, the Magnes.

Physician

/Medical

Director

Funeral

þ

Be Completed

other traumatic event, the Madical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Certification; To

Medical

25. Was case referred to medical 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 🗋 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D47353

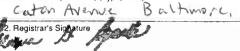
1 TYes 2 TNo

29d. Date signed (Month, Day, Year) March 19, 2004

30. Name and a press of pers in who completed cause of death (Item 23a) (Type, Print) Jon Falce Caton Avenue 900

State Registrar

31. Date filed (Month, Day, Year) MAR 2 3 2004



		1 - For State Registrar		epartment of Health and I Certificate of Death	Mental Hygien Reg. No	- Z 11 11 L 11 9 N 9 T
Physicia		1. Decedent's Name (First, Middle, Last,	A lones		2. Date of Death Month Da	3. Time of Death
/Medic Examin Funeral Director	-	4a. Facility Name (If not institution, give Stell of Mons 5. Social Security Number 6. Se 223-56-56-56-56-56-56-56-56-56-56-56-56-56-	HOSPICE 7. Age (In yrs. last birth	4b. City, Town, or Location of Death    1	8. Date of Birth (Month, Day, Year	Politimore  9. Birthplace (State or Foreign Country)
ore, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygione.  1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or Items 23s or 28e-1 show other treumatic event, the Medical Examinet must be notified at	rai Director	10a. State 10b. County  10e. Street and Number  8645 Glen Han	nore 10c. city, Town Nore Wir	101. Zip Code 21244		10d. Inside City Limits 1 □ Yes 2 No tizen of What Country?
215-0036 thin 72 hours after de le. an "natural", or Items Medical Examiner in	ted by Funerai	11. Marital Status  1 Never Married 22 Married  3 Widowed 4 Divorced  15. Decedent's Edu		13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert  1 ☐ Yes 2 No Specify:  Decedent's Usual Occupation	16b.	14. Race - American Indian, Black, White, etc.  Specify Black  (ind of Business/Industry
and 21215 be filed within 7 hal Hygiene. ed other than "n event, the Mad	Be Completed	(Specify only highest grad Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Give kind of work done during most of working DO NOT use retired)  18. Mother's Nam	PR (First, Middle, Maider	AGF Sumame)
Baltimore, Maryland permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other treumatic event once.	o	19a. Informant's Name/Relationship (Ty  20a. Method of Disposition  1 Burial 2 Cremation 3 F  Condition 5 Other (Specify)  21. Signature of Funeral Service Licens	11+e) SG 20b. Place of I cemetery. Garris	Mailing Address (Street and Number or Ru  A5 Glen Hannah  Disposition (Name of crematory or other place)  Sh Forest  22. Name and Address of Facility  23. Name and Address of Facility	Ct, Winds	or Town, State, Zip Code)  OR MIII MO 21244  ocation - City or Town, State
Physician /Medical		23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not be cause on each line.  CONGESTIVE HEAR.  Due to (or as a consequence of		or respiratory arrest,	Approximate Interval Between Onset and Death
R760, Cate be executed appropriate and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of			
O. Box 6 the death certific y the attending p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
cords, P. w requires that been signed b should be deta	by	Part II. Other significant conditions cor	ntributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
	e Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 🔀 No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
of V Physic r this ce ral direc	ToB	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 ER/Outp 28a. Date of Injury (Month, Day Year) 28b. Tir	atient 3 DOA Other: 4 Nursing H	th (Check only one)  ome 5 Residence  28d. Describe how injure	6 XOther (Specify) HOSPICE ry occurred
- Fare -	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town, State	
To the Hospitel of within 24 hours at To the Funerel D completely filled it	Medical	29a. Certifier (Check only one)  1 ⚠ Certifying Physical Examination (Check only one)  29b. Signature and title of certifier	sician: To the best of my knowledge, oner: On the basis of examination and/ and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur 29c. License number	red at the time, date and	and manner as stated. If place, and due to the cause(s)  te signed (Month, Day, Year)
1358		30. Name and address of person who co	mpleted cause of death (Item 23a) (To	D43721	3	3/18/04
Sta Registr		DR. TARTO MAHMOOI 31. Date filed (Month, Day, Year)			, MD 21093	

MARCH 17, 2004

EDDIE JONES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day March 17, 2004 **Physician** Padgett Jones 12:50p M Ellen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Months Dec 21, 1912 Director 91 Maryland 213-80-0933 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Ruxton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1208 Berwick Road 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ♥ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "in any injury or other traumatic event, Ilia Mad. page. than." Elementary/Secondary (0-12) College (1-4or 5+) 12 02 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Ellen Padgett Rankin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Malone/Daughter 790 46th St. (Gulf), Marathon, Florida Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/22/04 1 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens Timonium, Maryland 21. Signatura y Funeral Service Lifensye 22. Name and Address of Facility Bryan W. Clary Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) LEAT **Physician** ongest-ve Jean /Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Examiner physician and the burial-transit Physician/Medicai as signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month 4 Pregnant at time of death 5 Dther (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown disticile 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DDA | Other: 4 | Nursing Home 5 | Residence 6 Sother (Specify) (40 spice 1 ☐ Yes 2 No After this 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending 1 Natural To the Hospital or Attendinition 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide †© Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 125205 March 17, 200 4 and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Bolto. Md 2120x Rile BYNC 6701

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

AD PRUN JOSE Ph Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			9	Black Indelible In		vii Copies	Are Legible	•
		1 - For AMEND Item#7, per	State of Marylan FH, G829, 3/23/04,	id / Department o	f Health and I of Death	Mental Hy	giene 200	4 0909
Physicia	an	Decedent's Name (First, Middle, Last	) ) (	1/ 0 50 0 000	10	2. Date of De Month	path Day Yea	3. Time of Death
/Medic	cal	JOSEPH	VV.	KAPRAUN	JR.	3	20 04	1 3.101
Examin	ıer	4a. Facility Name (If not institution, give	uace Hosp	1 1	n, or Location of Deat	n	Bal+	oeth MOSE
uneral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Bir	th 9. B	lirthplace (State or Fore
rector		2\3\2\6966 \\ Usual Residence of Decedent	M 2□F 76 7	7 Yrs. Months Da	ys Hours Min.	APRIL	9,1927/	COUNTRY YLAN.
anow at at		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Lim
or 28a-f ahor be notified at	ctor	MARYLAND PAITIM	ORE B	ACTIMORE				1 ☐ Yes 2 🔀 1
OF AN	Funeral Director	10e. Street and Number		10f. Zip Cod	e 0 : 1		10g. Citizen of What	Country?
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iner	-une	11. Marital Status  1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U Armed Forces? 1 Dives 2 □ No	.S. 13. Was Decedent of Yes, specify C	of Hispanic Origin? (S Suban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - An Black, Wi	nerican Indian, hite, etc.
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nt,		17. Father's Name (First, Middle, Last)		LEITER	18 Mother's Nan	ne (First Middle	Maiden Sumame)	>
ic •	To Be	JOSEPH W.	KAPRAUN.	Sp.	0-	GIA N	1 10/10/5	SOR
emn.	-	19a. Informant's Name/Relationship (T)		19b. Mailing Address (Str			er, City or Town, State	Zip Code)
er tra		EILEEN KAPRA	UN /WIFE		JCOLNSHIRE	CT, P	ALTIMORE	MD 2123
or oth		20a. Method of Disposition  1 X Burial 2 Cremation 3 DF	20b. P	lace of Disposition (Name of emetery, crematory or other)	olace)	Date	20c. Location - City of	or Town, State
ojury .		`4 □Donation 5 □Other (Specify)	N	IBMOSIAL COM	DEND: WILK	CH 24200	TIMONIU	M, MARYL
eny ir		21. Signature of Funeral Service Licens	art and	22. Name and Ad	dress of Facility	VANS F	UNERAL C	HAPEL
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10	Examin Funeral	ier	4e. Fecility Name (If not institution, give s  3 3 0 0 MAY F  5. Social Security Number   6. Sex	AIR ROAD  7. Age (In yrs. last birth	4b. City, Town, or Location of Death  Aday) If Under 1 Year II Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	4c. County of Death  BALTI HORE  9. Birthplace (State or Foreign Country)	
altimore, Maryland 21215-0036	irmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland peatiment of Health and Mental Hygiene.  portant: if them 27 is marked other than "natural; or thams 23a or 28a-f show poportant: if them 27 is marked other than "natural; or tham 23a or 28a-f show popularity injury or other traumatic event. The Midical Examinating mail to a page 12.	To Be Completed by Funeral Director	Usuel Residence of Decedent  10a. State  10b. County  MARYLAND  BALT  10e. Street and Number  3300 MAYFA	10c. City, Town  1 MORE  10c. City, Town  1 MORE  12. Was Decedent Ever in U.S.  Armed Forces? 1 Moss 2 No If Yes, Give Year or Dates:  2 Completed)  College (1-4or 5+)  16a. If  Completed (1-4or 5+)  20b. Place of cemetery  CARR	or Location  BALTIMORE  10f. Zip Code  2 i 20  13. Was Decedent of Hispanic Origin? (S Il Yes, specify Cuban, Mexican, Puerl  1 Yes 2 No Specify:  Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)  18. Mother's Nar  Mailing Address (Street and Number or Ri  CANICK CT  Disposition (Name of commatory or other place)  122. Name and Address of Facility	pecify Yes or No- o Rican, etc.)  The (First, Middle, Maio  A ANA ural Route Number, Cit  Date 20c.  BRACON	DA ROBINSON  BY OF TOWN, State, Zip Code)  LAWN MD 21244  Location - City or Town, State  UNES MUS MC	5.
Box 68/60,	Physician and // Medical physician and // Medical physician and // Itor use as the burial-transit	Physician/Medical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of enter the mode of dying, such as cardiac (IVE HEART I):  BRULLATION  (1):  3 □ Ectopic pregnancy		Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and D	
Vital Records, P.O. t	v requires that the c been signed by the should be detached	Completed by Physici	Part II. Other significant conditions con  REVAL CELL  HYPERTEN	. CANCER	5 ☐ Other (specify) the underlying cause given in Part I.	1 ☐ Yes  24a. Was an autopsy performeg	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?	
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2	Certification: To Be Co	25. Was case referred to medical examiner?  1	28a. Date of Injury 28b. Ti	patient 3 DOA Other: 4 Nursing F me of iury Work? 1 Yes 2 No	28d. Describe how in	6 ☐Other (Specify)  njury occurred  and Number or Rural Route Number,	_
Ω	o the Hospital of thin 24 hours af the Funeral D impletely filled in	Medical Cer	29a. Certifier (Check only one)  29 Medical Examir  29b. Signature and title of certifier	ician: To the best of my knowledge, ler: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	irred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)  Date signed (Month, Day, Year)	_
1	× × × ×		30. Name and address of person who co	mpleted cause of death (Item 23a) (	0002408	89 0	3:11:04	_
E A	Sta Registi		31. Date filed (Month, Day, Year)  MAR 2 3 2004	32. Registrar's Signature	WARASH HVE.	BATI NY	10 21215	
DH	MH 17 Rev 1/2	Jul	WATER & 3 ZUU4	ORIO ORIO	GINAL			_

	1 - For State Registrar	State of Maryland	/ Department of Healt Certificate of Dea	th Reg.	No. 2004 09101
Physician /Medical	Decedent's Name (First, Middle, Last     HARRY L. MCCOW      4a. Facility Name (If not institution, give	AN	4b. City, Town, or Locat	march	Day Year 3. Time of Death 2:55 PM 4c. County of Deeth
Examiner	5. Social Security Number 6. S	re Hospital	Koseda	der 24 Hrs. 8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
Director	214-01-7781 Usual Residence of Decedent	91	Town or Location	4/26/1912	2 PENNSYLVANIA  10d. Inside City Limits
Marylar e-f show	10a. State 10b. County  MD BALTII		ARKVILLE		1 ☐ Yes 2 🌠 No
death with the Maryland ms 23a or 28e-f show rituat by Invitible at neeral Director	10e. Street and Number 1815 WENDOVER RO.	AD	10f. Zip Code 21234	10g.	Citizen of What Country?  USA
336 urs after urt, or its	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic If Yes, specify Cuban, Mer		14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-00 ed within 72 hou vygiener than 'nature is tra Medical E. t. tra Medical E. Completed	15. Decedent's E (Specify only highest gra-	ducation	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	most of working	b. Kind of Business/Industry
Baltimore, Maryland 21 Baltimore, Maryland 21 Bernit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If tem 27 is marked other th any injury or other traumatic event, the page.	17. Father's Name (First, Middle, Last,			lother's Name (First, Middle, Mai	STEEL, iden Sumame)
Maryla nd 2 should lith and Men 27 is marke r traumatic	19a. Informant's Name/Relationship (	Type, Print) RANDDAUGHTER	19b. Mailing Address (Street and No. 2305 FURNACE ROA		•
Baltimore, Managemii. Pages 1 and 2 Department of Health 2 Important: If them 27 is any injury or other transones.	20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State	ce of Disposition (Name of netery, crematory or other place)  LAND MEMORIAL PK		c. Location - City or Town, State HILLENDALE, MD
Baltimore Baltimore permit. Pages 1 Department of 1 Important: If le any injury or of once.	21. Signature of Funeral Service Licer		22. Name and Address of F	acility THE JOHNSON	N FUNERAL HOME, P.A. N. MD 21286
Physician /Medical Examiner	Part Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plic was that caused the death. cause on each line.  a. ASDITOTO  Due to (or as a conseque	Do not enter the mode of dying, suc	h as cardiac or respiratory arrest	
760, te be executed ysicien and he burial-transit		b. Due to for as a conseque  c. Due to (or as a conseque			
Box 68 eath certifica attending ph for use as the		23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
rds, P.	Part II. Other significant conditions of Renal Fail US	contributing to death but not result	ing in the underlying cause given in F	Part I. 23e. Did tobac	coo use contribute to the cause of death?
Division of Vital Records, P.O. or Attending Physician: The law requires that the diather death. Director: After this certificate has been signed by the lin by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached and in To Reformulated by Physical partitions to Reformulated by Physical partitions are suppressed in the property of the page 2 should be detached by Physical Phy	Anemia,	Metabolio	e Acidosis	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 □ No
of Vital F hysician: Th nis certificate Idirector, pag	25. Was case referred to medical examiner?	Hospital: 1X Inpatient 2 ☐ EI	Other	Place of Death <i>(Check only one)</i> Nursing Home 5 Residence	ce 6
ision of the death. ctor: After the funeral y the funeral is second.		(Month, Day Year)	8b. Time of Injury at Work?  M 1 □ Yes	28d. Describe how 2 \( \subseteq No	injury occurred
Division C  Division C  state death.  al Director: After t  ied in by the funera	3 Suicide 6 Could not be determined		e, farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Divis  Divis  To the Hospitel or Att within 24 hours after d To the Funeral Direct completely filled in by I	29a. Certifier 1 Certifying P. (Check only one) 2 Medical Exa		edge, death occurred at the time, da on and/or investigation, in my opinion		
To the virthing To the comp	1 Ohs	ens; in	29c. License num	81 m	Narch 20 2004
3 <sup>X</sup> State	30. Name and address of person who Dr Josephin Duvided (Month, Day, Year)	154-Sakyi 9000 22. Registrar's Signatu	23a) (Type, Print)  D Franklin Squar  ire	e Drive, Baltir	nore, MD 21237

Ple

ease Type or Print in Black Indelible Ink. Ensure	All Copies Are Legible.	
State of Maryland / Department of Health and	Mental Hygiene 2 () () 4	09102
Certificate of Death	Reg. No.	
ddle, Last)	2. Date of Death	3. Time of Death

			1 - For State Registrar		,	Cert	ificate of	Death	7		Reg. No.	<i>)</i> U 🤫	03102
			1. Decedent's Name (First, Middle, La	st)						2. Date of De		Year	3. Time of Death
	Physici /Medic		Philip R. Marti	n						March		2004	1830 M
	Examin		4a. Facility Name (If not institution, giv	e street and number	)		4b. City, Town,	or Location	of Death		4c. Coun	ity of Death	
			Carroll Hospita	1 Center				inste				Carro:	11
4	Funeral Director		213-22-6689	6ex 7. A ☑M 2☐F	ge (In yrs. last bir 76	rthday)_ Yrs.	Months Day:		r 24 Hrs. Min.	8. Date of Bir (Month, Da Jan. 2	th ay, Year) 29 1928	9. Birthp Cour Mar	ofece (State or Foreign ortry) cyland
	land		Usuet Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loca	ation					1	IOd. Inside City Limits
	Many f sh	ō	Maryland Carro	11	* g	wkee	ville						1 ☐ Yes 2 🖾 No
	28a	Director	10e. Street and Number	<u> </u>		yrcs	10f. Zip Code				10g. Citizen o	f What Cour	ntry?
	3a o		123 Streaker Roa	d			217	84			Unite	d Sta	tes
	deatl	Funeral	11. Marital Status	12. Was Decedent		13. W	as Decedent of Yes, specify Cu	Hispanic Or	rigin? (Spe	ecify Yes or No		ace - Ameno	
ဖွ	after or fte	Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☒ If Yes, Give			Yes 2 XN			rican, etc.)	Spec	lack, White,	
80	ural',	d by	3 Widowed 4 Divorced	Year or Dates:								Wn	
<u>7</u>	within 72 hours after death with the Maryland ene. than "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at	lete	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	(Give ki	int's Usual Occi ind of work don O NOT use retir	e during mos	st of worki	ing	16b. Kind of	Business/Ind	dustry
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Heatth and Mental Hygiene. If item 27 is marked other than "natural", or Itema 23a or 28a-f show or other traumatic event, it a Medical Examinat must be notified at	Completed	Elementary/Secondary (0-12)	Colfege (1-4or	5+)		Owner	00)			Exca	vatin	g Company
b	i Hygid other	BeC	17. Father's Name (First, Middle, Last,	)				18. Moth	er's Name	(First, Middle	, Maiden Suma	ame)	
lar	2 should be and Mental Is marked o	10 B	Philip E. Mar	tin				Vi	ola K	Kauffus			
an	and h		19a. Informant's Name/Relationship (	Туре, Print)							er, City or Tow	n, State, Zip	Code)
Σ,	Health Health tem 27		Theresa A. Martin	Wife			treaker	Road				21784	
ore	ges 1 t of H If ite		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □	Removal from State	cemete	ry, crema	tion (Name of atory or other pl			Date	20c. Location	-	
Ħ,	t. Partmen rtant: njury		'4 □Donation 5 □Other (Specif		Lake					1 23 20	04 Syk	esvil	le, MD
Bal	permit. Pages 1 and Department of Heali Important: if item 2 eny injury or other once.		21. Signature Funeral Service Licer	R	11100	bur	Name and Add	ieen Fi	unera	l Dire	ctors,	P.A.	vin 21784
<b>8.</b>	* - *		23a. Part1. Eriter the disease, or com	plications that cause	d the death. Do						Sykesvi rrest,	IIe, r	Approximate
	Physician		hock, of heart failure. List only Immediate cause (Final	one cause on each	line.	M.	ocardio	1 %		tual			Interval Between Onset and Death
	/Medical		disease of condition resulting in death)	a. Due to (or as	a consequence		e carolio	11 01	yan c	¥112		-	Haus
3	Examiner		Sequentially list conditions	h									
- 10	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence	of):							
	and and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequence	of):							
68760,	icate be executed physicien and s the burial-transit					0.7.							
687	srificate be executed ing physicien and e as the burial-transit	Medical		d									
Вох	8 0 8		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Fetaf death	. 3□E	Ectopic pregnan	cv				ate of delive	ery
	0 0	Physician/	in the past 12 months?  1 Yes 2 No		at time of death		Other (specify)	~y			N	/lonth	Day Year
P.0	ac p	Phy	9 ☐ Unknown  Part II. Other significant conditions of		but not requiting i	in the una	laching course	was in Dart		220 Did	ahasaa uga aa	atributa ta th	ne cause of death?
g,	ires tha signed I be det	l by	Part II. Other significant conditions of	contributing to death	but not resulting ii	n the und	ienying cause g	iven in rain	τ,	1 🗀	_/		ably 4 Dunknown
Ö	w requir been si should l	etec			<del></del>					24a. Was		- Woss suts	any finding a sysilable
Re	о <u>г</u> о	Completed								auto perfo	psy prmed2	prior to cor death?	psy findings available mpletion of cause of
tal		e Cc	25. Was case referred to medical					26 Plan	e of Death	1 Yes	2 No	1 Yes	2 No
>	Physician: this certificanal director,	OB	examiner? 1 Yes 2 No	Hospitaf:	ient 2/ER/Ou	utpatient	3 DOA	thor		-500	dence 6 🗆 O	ther (Specifi	v)
10	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da		Time of	28c. inj				how injury occu		
Siol	Attending r death. sctor: After	catle	2 Accident investigatio	n			M 1[	Yes 2					
Division of Vital Record	or Attendate death Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Flace of II	ijury - At home, fa tc. <i>(Specify)</i>	arm, stree	et, factory, office	)		28f. Location ( City or To	Street and Num wn, State)	iber or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Ce	29a. Certifier 1 Certifying Ph	nysician: To the bes	t of my knowledge	e death	occurred at the	time date ar	nd place	and due to the	causa(s) and n	nanner ac ci	rated
	e Hos 24 h e Fun etely	edical	(Check only 2 Medical Examone)	miner: On the basis and manner s	of examination an	nd/or inve	estigation, in my	opinion, dea	ath occurr	ed at the time,	date and place	, and due to	the cause(s)
	To the vithin To the complete	Me	29b. Signature and title of certifier				29c. Licer	nse number			29d. Date sign	ed (Month, I	Day, Year)
)			> MMZ				2 3	368	1	IND	3/2	2/04	
	10	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	30. Name and address of person who		death (Item 23a)	(Type, P	rint) Saido	114	51.	lersbn	(m)	7-1	784
	10		31. Date filed (Month, Day, Year)	380 Prod	rar's Signature	vay	, mite	11-1	, - 4		3	-1	701
	Sta Registr		MAR 2 3	- / /	Salara A	1	Santi P	Ÿ.					
DH	IMH 17 Rev 1/2	001			A CONTRACTOR OF THE PARTY OF TH	-							
					OR	IGINA	L						

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2004 Month **Physician** March20 1:33 A M John H. Moore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 17 Fir Drive Middle River 9. Birthplece (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1**∑**M 2□F 61 216-38-3607 Director Feb. 11, 1943 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinal must be notified at once. 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 1 Yes 2 No Middle River Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 USA 17 Fir Drive Funerai 14. Rece - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. l □Yes 2 □ No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 SpecifyWhite 1 ☐ Yes 2 ☐ No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) SocialSecurity Laboror 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lillian Frank Robert Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fir Drive Baltimore MD 21220 17 Rita Moore/wife Date 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 🏖 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 23/04 Baltimore MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee Onne 300 Mace Ave. Baltimore MD 21221 23a. Pert1. Enter the disease, or combinations that caused the dealt. Anot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List may be cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteriosclerotic Cardiovasci 10 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Be Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit attending physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year be detached for 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24a. Was an autopsy performed? 1 ☐ Yes 2 █ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☆ No certificate has Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Hospitel or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: / the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated ş 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signalure and title of certifier March 22, 2004 30. Name and address of person who completed duse of wath (Item 23a) (Type, Print) 32. Registrar's Signature DM. distil: MC State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Leona F. Miller 21 1325 March 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University Specialty Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
July 2, 1920 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 290-22-5199 6. Sex **Funeral** Months 1 □ M 2 🗓 F 83 Kentucky Director Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Martical Examiner must be notified at once. 1 ☐ Yes 2 No Director Maryland Baltimore Arbutus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1540 Sulphur Spring Rd. 21227 U. S. A. Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 f Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify. White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Caretaker Self Employed 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown ٩ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheilia Michno, granddaughter 1540 Sulphur Spring Rd. Arbutus, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 XOther (Specify) 03-24-2004 Etna Cemetery New Bank, KY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility al Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** nt Septicemin) resulting in death) /Medical Due to (or as a consequence of): Examiner d penjorned Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury) Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Box 68760 The law requires that the death certificate be Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Hailire rent dependent 1 ☐ Yes 2 DNo 3 Probably 4 Unknown auce Rond Jailure Hearl Heuline 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an in by the funeral director, page 2 autopsy performed? Chrine phsmetive pulm onory diseuse 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending after death. investigation 1 TYes 2 □No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D30494 3/21/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhmore MORRYS KNESAIM 716 Marcien choice lane 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

MILLO

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Merrick 18 Joseph 1:18 РМ March 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A 3113 St. Paul Street, Apartment 11 Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3-22-1952 Birthplece (State or Foreign Country)
 OR 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 10XM 2□F 541-64-6352 51 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatith and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahov any injury or other traumatic event. The Medical Exercises must be notified at MD Baltimore Baltimore City 1 X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 USA 3113 St. Paul St., #11 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ∏XYes 2 ☐ No Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify: Specify. white 3 ☐ Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Military mechanic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence F. Szymarek Joseph Merrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 351 Gatewater Crt #202 Glen Burnie MD 21060 Mrs. Florence Merrick/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burnal 2 X Cremation \_ 3 ☐ Removal from State 3/19/2004 Stevensville, MD Chesapeake Cremation ' 4 □ ponation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home 21. Sign ture of Funeral Service Licenses pnce M01364 1 Second Ave SW Glen Burnie MD 21061 UNNUR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Alcoho 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy ₫ Day Year Month 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 3 Probably 4 Unknown 1 Yes 2 XVo 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 🗌 Yes 1 Yes 2 No. or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at SCENE To 1 1 XYes 2 □ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Fo the Hospital filled t 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho To the Fune completely fi 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tille of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 19, 2004 30. Name and address completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

	-	For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of H	lealth and Death	Mental Hyg	giene 2 (	001	09107
Physicia /Medica		1. Decedent's Name (First, Middle, Audrey Mar	,	ıglia				2. Date of Dea Month Merch	Day it	Year 2004	3. Time of Death 21:06 M
Examine	er	4a. Facility Name (If not institution, 19 Upper Chesapeak	e Hospi	tal		Ве	r Location of Deat L Air				ford
Funeral Director		215-01-9206	.Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Day Aug. 15	v. Year)	9. Birthp Coun	lace (State or Foreign htry) Maryland
death with the Maryland ms 23a or 28a-f show rmust be retified at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Har	hord	10c. C	ity, Town or Lo	cation  Joppad	towne			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
ath with the	rai Director	10e. Street and Number 63 Neptune Drive					21085			S. A.	•
US after urs after Exertine	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed I	2 No Sive No		Was Decedent of H fYes, specify Cuba 1 ☐ Yes 2 🛣 No		pecify Yes or No- to Rican, etc.)	Spec	ace - Americ ack, White, ify:	
VIZID-UUS Jene. r than "natural", the Medical Exe	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed	1) (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of		•
De fill Hall Hall Hall Hall Hall Hall Hall H	To Be Co	12th Grade 17. Father's Name (First, Middle, La Charles Rowley	est)		1	Homen	18. Mother's Na	me (First, Middle,	Maiden Suma	wn Hor <sup>me)</sup>	ne
Mary nd 2 shoulth and M 27 is mar		19a. Informant's Name/Relationship Debbie Neville		aughter!		ng Address (Street	and Number or Ri	ural Route Numbe	r, City or Town		
altimore, mit Pages 1 ar partment of Hea portant: if item y in ury or othe		20a. Method of Disposition  1 X Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe	☐Removal from	20b.	Place of Dispo	sition (Name of natory or other place	ce)	Date / 2004	20c. Location	- City or To	wn, State
Battime permit Pag Department Important: I any injury o		21. Signature of Funeral Service Li	censee			Name and Addre	ss of Facility So	chimunek	Funera	l Home	es
Physician /Medical		23a Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. A	each line.		1		1108	,	<	Approximate Interval Between Onset and Death
Examiner us us and post of the use of the us	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	Certa o (or as a conse	quence of):	Kemia	du	e fo	Asth	ma,	minutes
o ≅ d s	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	1 🗆 Live	outcome of pregr birth 2 Fet gnant at time of snown	tal death 3	Ectopic pregnancy				ate of delive	ory Day Year
COTGS, P. w requires that been signed b should be deta	ρ	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.		obacco use cor res 2 □ No	ntribute to th	ably 4 Nuknown
	Completed							24a. Was autop perfor 1 🗆 Yes		. Were autop prior to con death? 1 \( \sum \text{Yes}	psy findings available impletion of cause of 2 No
on of aling Phys	tion; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investiga	28a. Dat (Mo	Inpatient 2 e of Injury onth, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	er: 4 Nursing H	ath (Check only on Home 5 Residence 1986). Describe h	lence 6 🗆 Ot		•)
DIVISION Of all or Attending Phy s after death. I Director: After this id in by the funeral of	Certification	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Pla	ce of Injury - At I ding, etc. (Spec	home, farm, str sify)	eet, factory, office		28f. Location (S City or Tow		nber or Rura	l Route Number,
DIVISIC To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical E	caminer: On the	he best of my kr basis of examin inner stated.	nation and/or in	occurred at the tirvestigation, in my o	pinion, death occi	arred at the time, o	date and place	, and due to	the cause(s)
To T Com	Σ	29b. Signature and title of certifier		Mi		29c. Licens	9566C	7	29d. Date sign Morcy	ed (Month, L 2 C	Day, Year)  1th, 2004  MD 21014
4			1GELO	# 10		Print) 02 Sc	reth At	wood K	ed, BE	LASK	MD 21014
State Registra		31. Date liled (Month, Day, Year)  MAD 2 2 2		Registrar's Sign	,	/	1,				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MARCH 20. 11:40 2004 locenco /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Joseph Medical Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday)

Yrs. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F 215-24-1694 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show item 27 is marked other than "natural", or iteme 23s or 28s-f shov other traumatic event. Its Mcdical Examiner naid be notified at 1 ☐ Yes 2 No MD Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21085 10210 Side Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status iiled within 72 hours after 1 Never Married 2 Marned 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Massonic a 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) RESTON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Morri 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Department of h Important: If its any injury or of 5 Cenutery 3-23-04. Socks MID
22. Name and Address of Polity 2325 YORK 25 TIMONION MID 21093 Important: 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee PERCEPULALTERNATIVES FLIXERALICREMATION CTR 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) JROSEPSIS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disactory in Juny that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burial-1 physician Box 68760, thet use as t attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 Do
9 Unknown Month Day Year 4 Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate har ral director, page 1 Yes 1 Yes 25 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 X Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ☐ Accident Director: / 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral D 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 29c. License number ella D 41410 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. 7601 MEHTA. M. D. OSLER DRIVE. TOWSON. MARYLAND 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 2 3 2004 Registrar

		4	For State Registrar	State of M	farylan		artment of H rtificate of				ene g. No. 20	04	09109
Q-	*		Decedent's Name (First, Middle, L.)	ast)					2	2. Date of Death Month	1	'anr	3. Time of Death
, vi - (1)	Physicia /Medic	_	Harry Dani	el McCar	thy				1	1Arch		O4	2105 M
	Examin		4a. Facility Name (If not institution, g	ive street and numbe	r)		4b. City, Town, o	or Location	of Death		4c. County of	4 .	
			Union Memoria			la a à fairetanta l	Balti If Under 1 Year		24 Hrs   0	B. Date of Birth		N / A	and (State or Foreign
	Funeral Director	- 1	5. Social Security Number 6. 220–42–3712	Sex 7. A 1 ★ 2 ☐ F	57	last birthday) Yrs.	Months Days	Hours	Min.	(Month, Day,			ace (State or Foreign try)
		-	Usual Residence of Decedent							Jan. 9,	1947	lary.	
1	how	_	Maryland N/A		10c. Cit	y, Town or Lo Baltii						10	0d. Inside City Limits XX Yes 2 □ No
	8e-f	Director	Tal yland			Darti				10	g. Citizen of Wh	at Caus	
1	e or 2	급	10e. Street and Number 3503 Falls Road				10f. Zip Code	212	11	10	-	SA	uy:
	ns 23	Funeral	11. Marital Status	12. Was Deceder		.S. 13.	Was Decedent of I	Hispanic Or	igin? (Speci	ify Yes or No-	14. Race -	America	
336	permit. Pages 1 and 2 should be lied within 72 nouts after death with the maryland Department of Health and Mental Hyglene. Importent: If time X7 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	by	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Force: 1 Ty Yes 2 If Yes, Give Year or Dates	] No		If Yes, specify Cub 1 ☐ Yes XX No			ican, etc.)	Specify:	White, e	White
် လ	naturi	Completed	15. Decedent's (Specify only highest of	Education brade completed)		(Give	dent's Usual Occup	during mos	st of working		6b. Kind of Busi	ness/Ind	dustry
2	affinin en	nple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	<i>DO NOT use retire</i> tenance E	d)			Proport	и Мо	nagement
2	lled w Hygler her ti		12 17. Father's Name (First, Middle, La	st)		nain	tenance 1				laiden Sumame)		nagement
anc	d be t ental h	o Be	Daniel McCarth							. Eaton			
Maryland 21215-0036	Should nd Me mark imatic	၉	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	t and Numb	er or Rural i	Route Number,	City or Town, Si	ate, Zip	Code)
<b>S</b>	alth ar		Deborah McCarthy	Wife	9	350	3 Falls R	Road,	Balti	more, M	aryland	212	11
ore,	of Hei	F	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□Removal from Sta		cemetery, cre	osition (Name of matory or other pla	ice)	Da		20c. Location - C		
<u>Ĕ</u> ,	Pag ment ent: I		* 4 □ Donation 5 □ Other (Spe	city)	Pi		ve Cemete		3/23/		Rayville		
Baltimore,	permit. Depart Import any inj		21. Signature 1 Funeral Service Lic	Henss		B <sub>1</sub>	2 Name and Address 1rgee-Hen 531 Falls	ess of Facili 188–Se 8 Road	itz F Bal	uneral	Home, In Marylan	ıc.	21211
	鸟。		23a. Part1. Enfer the disease, or co shock, or heart failure. List on	mplications that caus ly one cause on each	ed the deat	th. Do not en	ter the mode of dy	ing, such as	s cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition	a Cor	ono	en Ch	ten L	liser	Al				Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or	s a consec	pence of):	) din	^ .					
8	_xamare,	-	Sequentially list conditions,	b. IT n	d ) to	to~o ∕	enal D	113-005	10				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to a mediate cause. Enter Underlying Cause (Disease or injury that initiated events	550 15 (51		3							
<u>_</u>	execu n and ial-tra	Exal	resulting in death) Last	C. Due to (or	as a consec	quence of):							
8760,	icate be executed physician and s the burial-transit	dical		d									
89	ntifica ng ph as th	Medi	IF FEMALE:										
Вох	death certificate be executed e attending physician and ed for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth	2 Feta	al death 3	□Ectopic pregnanc	су			23d. Date Mont		ry Day Year
0.	the all	/slcl	1 Yes 2 No	4□Pregnant 9□Unknown		death 5	Other (specify)						
<u>d</u>	requires that the de een signed by the a hould be detached f	Ph	Part II. Other significant condition	s contributing to deat	but not res	sulting in the	underlying cause gr	iven in Part	I.	23e. Did tob	acco use contrib	ute to th	ne cause of death?
ds,	uires sign ld be	d by	_							1 ☐ Ye	s 2 🗆 No 3	☐ Prob	ably 4 Unknown
S	× 0 0	Completed								24a. Was an			psy findings available
Re	has has	E O								autopsy perform	ned? de	or to con ath? ∃Yes	impletion of cause of
ita	icien: Th certificate rector, pag	a	25. Was case referred to medical					26. Plac	e of Death	(Check only one			
>	S S	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	itient 21	R/Outpatie	nt 3 DOA	ther: 4 🗆 N			nce 6 Other		y)
0	ng Pt (fter t† Ineral		27. Manner of Death 1 ☑Natural 5 ☐ Pending		njury Day Year)	28b. Time Injury	Wo	ork?		3d. Describe ho	w injury occurred	1	
Sio	Attending ir death. ector: Aftei by the fune	cat	2 Accident investiga 3 Suicide 6 Could no	t be Igo Bloom of	loius. Ath	omo farm c	M 1 [	Yes 2		Bf Location (St	reet and Number	or Bura	l Route Number
É	l or Al after Direc	Certification:	4 Homicide determin	ed building,	etc. (Speci	ify)	riest, ractory, office	,		City or Town			
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying	Physician: To the be	st of my kn	owledge, dea	th occurred at the t	time, date a	ind place, ar	nd due to the ca	use(s) and man	ner as st	tated.
	n 24 h n 24 h he Fu.	Medical	(Check only 2 Medical Ex	taminer: On the basi and manner		ation and/or i	nvestigation, in my	opinion, de	ath occurred				
	To the within 2 To the complet	Σ	29b. Signature and tille of ertifier	21				nse number			9d. Date signed		
•	1.		Glert	hortes			Do	053	537		3-/9-	04	
	10		30. Name and address of person w	no completed cause of	of death (Ite	m 23a) (Type	Print)	< 1	R.		Ma 1 .	717	18
	C+	ate	DR. ROBERT LIN 31. Date filed (Month, Day, Year)	32. <b>M</b> eq	strar's Sign	N / IE!	ONIAL ITO	FITAL	UNL	TIMORE,	viaryland		7 6
	Regist		MAR 2 3	2004	Esta .	B. P	Print)  YORIAL Ha						

			1 - For State Registrar	State of Ma	aryland / De <i>C</i>	partm ertific	ent of Heate of E	ealth and . Death		ene 2 (	004	09110
П	Physici	an	1. Decedent's Name (First, Middle, Las.	•					2. Date of Death	Day	Year	3. Time of Death
	/Medic		Frank Charles M						March	17 2	004	11: 25 AM
	Examin	er	4a. Facility Name (If not institution, give			4b. (		Location of Deat	h	4c. County		
	Funeral		Homewood @Willian  5. Social Security Number 6. Se		e (In yrs. last birthd	ay) If U	Williar nder 1 Year	nsport If Under 24 Hrs	8. Date of Birth	Wash		n lece (Stete or Foreign
	Director	9	220-07-4413	<b>X</b> M 2□ F	85 Yrs	Mon	ths Days	Hours Min.	(Month, Day,	Year) 1919	Coun	itry)
	pur *		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						0d. Inside City Limits
	Maryla f sho	ō									''	1 Yes 2 No
	28a-	rect	MD Baltimor	e	Spar		. Zip Code		10	g. Citizen of \	What Coun	
	h with	a D	2315 Traceys Rd.				21152	2		US	Α	
	ems er m	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		3. Was D	ecedent of His		pecify Yes or No-	14. Rac	e - America ck, White, e	
36	s afte	<b>by</b> F.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 N If Yes, Give	lo	_	s 20XNo	Specify:		Specify		vhite
21215-0036	72 hours after death with the Maryland neturel", or Items 23a or 28a-f show Jical Esant set must be molified at	ed b	15. Decedent's Edi	Year or Dates:	16a. De	cedent's	Usual Occupa	tion		6b. Kind of Bi		
215	within 72 ene. than "ne	Completed	(Specify only highest grad		(G	ive kind o		uring most of wor	rking	ob. Tand or Br	33110331110	id Str y
	filed wit Hygiene ther tha	Com	11	n/a		lachi	nist			Cardb	oard	
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7	should be nd Mental marked o	ဥ	George Stanley M  19a. Informant's Name/Relationship (T)		10b M	siline Add	roos (Stroot o		M. Smit		01111	
Z	ith a		Deborah A. Price	-					arks, MI			Code)
ē,	ages 1 and 3 nt of Health : If item 27 or other tr		20a. Method of Disposition		20b. Place of Dis	sposition		1	Date 2	0c. Location -		wn, State
E	Pages nent of int: if it iry or o		1 Surial 2 Cremation 3 □I  1 Dongtion 5 □ Other (Specify)		1			13/20	7/04 Gardens	Timoniı	um. N	ΛD
Baltimore,	permit. Page Department of important: if any injury or once.		21. St. Fe of Funeral Service 1	layer		Lemi	e and Address	of Facility	ome of D	ulanev	Valle	ev. Inc.
	,		Bryan W. Cta 23a. Part 1. Enter the disease, or comp shock, hear failure. List only o	lica ions that used								Approximate Interval Between
	Physician		Immediate C u se Final disease or con Tilon	J. HN	phosotol	SKo	160	Viz 116	sulard	17/17		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		LUC	1-10-00	oce year of	1000	7	ews,
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	uted I ansit	Examiner	Cause. Enter Underlying		. 0011004001100 01).							
o,	exect an and rial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of);							
68760,	eath certificate be executed attending physician and for use as the burial-transit	dicai		d								
_	entifica ling ph e as t		IF FEMALE:		-							
Вох	ath cattend	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal death		c pregnancy			23d. Dat Mor	e of deliver	ry Day Year
P.O.	the de	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t 9☐Unknown	time or death	o ∐ Other	(specify)					,
	The law requires that the death certif Ite has been signed by the attending page 2 should be detached for use a:	by Pr	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the	шоderlyii	gcause giver	n in Part I.	23e. Did toba	icco use contr	bute to the	e cause of death?
Records,	w require been sig should b	ed b	Dictoer Wellita (	Well K	Wialto	Sill	4104		1 🗌 Yes	2 🗆 No	3 Proba	ably 4 □Unknown
ooa	e law re has be ge 2 sho	Completed	Hyportarión	, Crusha	coma.	10.	rest	he	24a. Was an autopsy			sy findings available
<u>۳</u>	The cate h	Сош	Wort Faiture	/ • (	,		J		perform	ed? d	leath?	
Vital	Physicien: r this certifica ral director, I	Be	25. Was case referred to medical examiner?	Hospital:					th (Check only one			
	Phys r this ral dir	. To	1 ☐ Yes 252No	1 ☐ Inpatier 28a. Date of Injury			DOA Other	Nursing H	ome 5 Resider			
O	Attending or death.	ition	1 Natural 5 ☐ Pending investigation	(Month, Day	Year) Injur		Work?		20d. Describe nov	injury occurr	<b>5</b> G	
Division of	Atter or dea octor by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, farm,	street, fac	ctory, office		28f. Location (Stre		er or Rural	Route Number,
ā	ital or A rs after al Directed in by	Ceri		Dallaking, blo.	· (Opocny)				City or Town,	Siale)		
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2   Medicar Exami	sician: To the best o	examination and/or	ath occur investiga	red at the time tion, in my opi	, date and place nion, death occur	and due to the cau	se(s) and mai	nner as sta	ted. the cause(s)
	thin 2 o the orplet	Med	one)  29b. Signature and title of certifie	and manner stat	led.	-	29c. License			d. Date signed		
)	~		· ///				7	766	26	V-	/ /-	2 26200
	10	1	30 Name and addr so of person who co	omplus cause of de	ath (Item 23a) (Typ	e, Print)		0000	10 1	100	1/	1,007
			HW WW	1471	10/40	n/	Tho	Her	a Va	L, A	10 Z	2/742
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	Registr	air	MAR 2 3 2004	South AR.	il a	The same	/					

PM 04-01917 Donna Moon

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			1 - State Unpend Item#23a,P	art II,27,28a-T	Per Mr.	rtifica	3/24/0 ate of i	deg Death		Reg. N	Z U	U 4	0911	
F	hysici /Medic		Decedent's Name (First, Middle, Last)	Donna M	oon				2. Date Mont Mar	of Death th C Ch 1	7,	2004	3. Time of De 16:45	eath M
	Examin		4a. Facility Name (If not institution, give s 2602 Miles Avenue	treet and number)		4b. Ci		Location of Dea	ath		c. Count	y of Death		
	uneral rector		5. Social Security Number 213-84-3159 6. Sex 1 □	м 2XX 7. Age (In yrs. 42	last birthday, Yrs.	Month	der 1 Year ns Days	If Under 24 Hr Hours Mir	B. Date (Mon.	of Birth th, Day, Yea 4	1961	9. Birthp Coun MAr	lace (State or F try) yland	-oreign
faryland	ehow ed at	or	Usual Residence of Decedent  10a. State 10b. County N	/ A 10c. Ci	ty, Town or L Balt:		re					11	0d. Inside City I	
with the A	a or 28a-1 Lbe notifi	Director	10e. Street and Number 2602 Miles Ave	nue		t	Zip Code				Citizen of	What Coun	try?	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	Important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow any injury or other traumatic event. The Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed X X Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes X☐XNo If Yes, Give Year or Dates:		Was De		ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes into Rican, et		14. Ra Bla	ce - Americ ck, White, o	etc.	
Maryland 21215-0036 to 2 should be filed within 72 hours af tith and Mental Hygiene.	r then "nature the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 10th		(Give	dent's U kind of DO NOT itre		ation during most of wi f)	orking	16b.		usiness/Inc	•	
land A	rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last)	James Cori	nelius	S		18. Mother's Na Evel	yn Fr		n Sumai	ne)		
Mary and 2 short atth and N	27 is ma er trauma		19a. Informant's Name/Relationship (Type Jamie Corneli					enry C		Number, City Balto			Code) 1237	
Baltimore, permit. Pages 1 ar Department of Hea	nt: If item ry or oth		20a. Method of Disposition 1 ☐ Burial **** A ☐ Cremation 3 ☐ Royal ** 4 ☐ Donation 5 ☐ Qther (Specify)	emoval from State B	Place of Dispo cemetery, cre 11to/V	osition (f matory o Vast	Vame of or other place 1 Cre	matory	3 / 2 1	20c. /4 ]	Location Laur	$\mathrm{e}1$ ,	wn, State MD	
Balti permit. Departn	Importa any inju 2008.		21. Signature of Funeral Service License	Dente	2	2. Name	ee-H Fal	ss of Facility Enss-S Is Roa	eitz d Ba	Funer	A 1	Н949	Inc.	
Phy	sician		23a. Part I. Inter the disease, or complice shock, heart failure. List only on Immediate Cause (Final disease or condition	nons that caused the deal e cause on each tine.	th. Do not en	ter the m	node of dyin	g, such as cardia	ac or respirat	tory arrest,			Approximate Interval Betwee Onset and Dea	en
<b>∞ /M</b>	edical miner		resulting in death)	Due to (or as a consec										
petno	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):									
8760, sate be executed	physician and s the burial-transit	cai	resulting in death) Last	Due to (or as a consec	juence of):						_			1
I Records, P.O. Box 68 The law requires that the death certifical	ed by the attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of c	ıl death 3		pregnancy (specify)					ite of deliver	ry Day Yea	ar
ds, P	should be deta	d by Pr	Part II. Other significant conditions con Pneumonia; HIV seroposi	-	ulting in the u	ınderlyin	g cause give	en in Part I.	23e.	Did tobacco			e cause of deat	
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of Vita Physician:	this certificate ha al director, page	To Be	25. Was case referred to medical examiner?  1XX es 2 □ No	ospital: 1   Inpatient 2	ER/Outpatie	nt 3	DOA Othe	26. Place of De en: 4 ☐ Nursing	-		6 <b>X</b> Oth	ner (Specify	SCENE	1
Vision O Attending PI r death.	rr: After th	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 3/17/04	28b. Time o Injury Unknown		28c. Injun Worl	vat √? Yes 2 <b>X</b> No	28d. Desc	cribe how inj VN	ury occur	red		
DIVIS	To the Funeral Director: After completely filled in by the funer.	Certification:	3 ☐ Suicide 6 ☑ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special home		reet, fact	tory, office		City	tion (Street a or Town, Sta <b>files A</b> v	te)		Route Number e, MD	r.
Div So the Hospital or within 24 hours afte	e Funer etely fill	Medical	29a Certifier 1 Certifying Physical Check only Code	ician: To the best of my knower: On the basis of examinating and manner stated.	owledge, deat ation and/or in	h occurrivestigati	ed at the timion, in my of	ne, date and place pinion, death occ	e, and due to curred at the	o the cause( time, date ar	s) and ma nd place,	anner as sta and due to	ated. the cause(s)	
To the	Toth	Me	29b. Signature and title of certifier	. ^		- 1	29c. License			29d. D	ate signe	d (Month, E	Day, Year)	
'B	Com	1	Horsell		n 22a\ /T:	Brien)		O.C.M.E.		Ma	rch .	18, 20	004	
/3	ha		J. Whenlake	mpleted cause of death (Iter	111		nn Sti	reet, Ba	ltimor	e, Ma	ryla	nd 212	201	
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 2 3 7004	32 Registrar's Signa	ature	ants 1	,							

DHMH 17 Rev 1/2001

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month .Physician 18, 2004 4c. County of Death Bessie May Mitchell MARC /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Stella Maris at Mercy Hospital Baltimore If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) July 1, 1944 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🕏 F 217 58 1749 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a. State 10b. County Maryland N/A Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4129 Audrey Avenue 21225 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, parmit. Pages 1 and 2 should be filed within 72 hours effer to Depertment of Haelth and Mantal Hygiana. Important: If item 27 is merked other than "natural", or item any injury or other traumant. 1 Never Married 2 Married 1 Tes 2√2 No Specify: Specify: White Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Vending Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elmer A. Coleman Anna May Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MITCHELL Roland Mitchell Sr. / Husband 4129 Audrey Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 4001 Ritchie Highway nt1. Enter the diseas for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Canco Examiner Physician/Medical Examiner Physician: The law requires that the deeth cartificete be executed usa as the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 20 No Certification: To 1 ☐ Yes 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) or Attending 5 Pending investigation Injury 1/ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) complately filled in by 4 🗌 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edlcai (Check only and manner stated. within 2

Baltimore, Maryland 21225
Date 20c. Location - City or Town, State 3/22/04 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 29c. License number 40854 3/11/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore St Registrar's Signature **ORIGINAL** 

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ¥ Yes 2 □ No

Mary Land

Black, White, etc.

State Registrar

29b. Signature and title of certifie

31. Date filed MARO 3 3ar 2004

			riease	Chate of Manuford					
			For State	State of Maryland	•	eate of Death			4 19113
			Registrar  1. Decedent's Name (First, Middle, Las	zt)	Certino	ale of Dealif	2. Date of Deat	ig. 140.	3. Time of Death
	ysicia		FRANCES L.	PFEIFFER			Month MARCH	Day Year 17 2004	1:30 A. M
	Medic camin		4a. Fecility Name (If not institution, give		4b.	City, Town, or Location of Dea		4c. County of Dear	
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Fur	neral		5. Social Security Number 6. Se		Mor	Inder 1 Year If Under 24 Hr hths Days Hours Mir		Year) 9. Bird	thplace (State or Foreign
Dire	ector		Usual Residence of Decedent	3 280	Yrs.		June 1,	1920 MG	iryland
land	=		10a. State 10b. County	10c. City, T	Town or Location	1	· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
Manylan -f show	7	to	PA VORK	FAIL	W 66	ane and			1 ☐ Yes 2 No
ith the M	DOI 0	Funeral Director	10e. Street and Number	11 0000	10	f. Zip Code	10	g. Citizen of What Co	ountry?
uth wit	at be	aiD	267 BRYANSVI	lle Rd.		17321		USA	
er dea	ME ES	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was D	ecedent of Hispanic Origin? ( specify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, Whit	
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If E 12.15-0000 filed within 72 hours after death with the Maryland Hygione.	ST ES	ed b	15. Decedent's Ed	Year or Dates:	16a. Decedent's	Usual Occupation		16b. Kind of Business	Industry
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2 should be filed within and Mental Hygiene.	atic	ဥ	JEHLRSON	walsh		Irae	gueet !	Chalitz	KY
d 2 st d 2 st h and 7 is n	other traumatic event, the Medical Examiner trust be notified at		19a. Informant's Marne/Relationship	ype, Print)	19b. Mailing Add	dress (Street and Number of	A FALL	City or Town, State, 2	Zip Code) DA 17321
1 and Health	other		20a. Method of Disposition	20b. Plac	e of Disposition	(Name of	Date 10	20c. Location - City or	Town, State
Pages Tent of	any injury or other tr once.		1 Burial 2 □ Cremation 3 □  4 □ Donation /5 □ Other (Specify	Hemoval from State	etery, cremators	or other place) Ma	PCN 17	HOOLBUR,	vie MI)
permit. Pag Department Important:	iniu		21. Signature of Funeral Service Lifeen		22. Nan	ne and Address of Facility	vaus Fun	opal Chas	el-Boldie
2 8 8 8	any ir		KRIHAND	tells	314	ewport DR	FORAST 1	fell MD	2/050
	- 4		23a Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death. I one cause on each line.	Do not enter the	mode of dying, such as cardi	ac or respiratory arre	st,	Approximate Interval Between
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be de	chedi	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	n 5∐Otne	or (specify)			
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requires	ad bi	ed by	hyperter				1 🗆 Ye	s 2 No 3 Pr	obably 4 SUnknown
S w g	s sho	plet	destreles				24a. Was ar	24b. Were au	utopsy findings available completion of cause of
The I	page	Completed			_		autopsy perform	ied? death?	1
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Physic 2	al dire	70	1 ☐ Yes 2 ▼No	Hospital: 1 Inpatient 2 ER				nce 6 Other (Spe	cify)
ding F	funer	ion	27. Manner of Death  Natural 5 Pending  2 Accident investigation	(Month, Day Year)	Bb. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
Attend	y the	fical	3 Suicide 6 Could not be	e 28e. Place of Injury - At home			28f. Location (Str	eet and Number or Ru	ural Route Number,
after Dies	dinb	Certification:	4  Homicide	building, etc. (Specify)		•	City or Town	, State)	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Europea Disorder Attentific certificate has been singed by the attending driver.	completely filled in by the funeral director, page 2		29a. Certifier  (Check only 2 Madical Exam	ysician: To the best of my knowle	edge, death occu	irred at the time, date and place	ce, and due to the ca	use(s) end manner as	s stated.
the H in 24	nplete	<b>l</b> edical	one)	and manner stated.	T and of investig				
5 time	00	×	29b. Signature and title of certifier			29c. License number		d. Date signed (Mont	
	10		20 Name and address of	completed course of death (Its - 21	3a) (Tuna Brier)	932255		MARCH 17	12004
	5		30. Name and address of person who DAVID DUNN,	MD 615 W.		IL ROAD, BEL	AIR, MD	21014	
撼	Sta	te	31. Date filed (Month, Day, Year) MAR 2 3 200	A Registrar's Signature				72027	
R	egistr	ar	MAR 23 ZUU	4 States S.	FEFFE VIEW	<i>9</i>			

	a		1 - For State Registrar	State of	Marylan	*	artment of rtificate of	Health and N		Reg. No.	004	09114
	Physici	an	Decedent's Name (First, Midd)	e, Last)					2. Date of D	Day	Year	3. Time of Death
	/Medic		Philias	F.	had.	Pro	vost	or Location of Death		18, 200	04 ty of Death	3:40 p <sup>™</sup>
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V <sub>2</sub>	Director		010-09-8166	1 <b>∑</b> M 2□F	88	Yrs.	World Day	s Hours Will.	Aug 4,	1915		rmont
٤ -	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits
à	the Marylar 28a-f show	to	Maryland Ba	ltimore		Ra	ltimore					1 □ Yes 2 No
0	or 28a	Director	Maryland Ba 10e. Street and Number	ICIMOTE		Ба	10f. Zip Code			10g. Citizen of	What Cou	ntry?
I	15 w	ai D	8100 Rossville	Blvd.				236			SA	
m	ter dea	ner	11. Marital Status	12. Was Deced Armed Ford	ces?	.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Sp iban, Mexican, Puerto	pecify Yes or N Rican, etc.)	0- 14. Ra Bla	ace - Ameri ack, White,	
36	s afte	by Funerai	1 ☐ Never Married 2 ☐ Mar 3 🎖 Widowed 4 ☐ Divorced	If Yes, Give	,		1 ☐ Yes 2🏋 N	o Specify:		Spec	ify: Whi	ite
5-0036	naturaf	ted t	15. Deceder	nt's Education	100.	16a. Dece	edent's Usual Occ	upation		16b. Kind of		
7215	hin 72 3. Bin "na Medi	ple	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-	4or 5+)	lite.	b kind of work don DO NOT use retii	ie during most of work red)	king			
2 2	70 70 =	Completed	12	04		T	echnical				rospa	ce
	e d la b	Be	17. Father's Name (First, Middle,					18. Mother's Nam		e, Maiden Suma		
~ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	2255	2	Francis  19a, Informant's Name/Relations	H.	Pro	vost 19b. Mail	ing Address (Stre	et and Number or Rui	Leona ral Route Numi	oer. City or Town	Grig n. State. Zii	
N S			Phyllis Forsyt		r			dre Court				1236
اع ک	es 1 and 2 of Health a f itam 27 li		20a. Method of Disposition		20b. F	Place of Disp	osition (Name of ematory or other p		Date 2/04	20c. Location		own, State
ARCh altimore.	Pages nent of I ant: # it		1 🌠 Burial 2 □ Cremation  1 4 □ Donation 5 □ Other (5		Du	laney	Valley M	lem. Grdns	•	Timoni	um, M	aryland
Balti	permit. Page Department of Important: if any injury or once.		21. Signature of Funery Service Michael J.	Flagle	agle		2. Name and Add emmon Fu O W. Pad	ress of Facility Ineral Home Ionia Road	e of Du , Timon	laney Vaium, Ma	alley rylan	Inc. d 21093
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	r complications that da only one cause on ea	used the deat ich ine.		iter the mode of $d$		or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a conseq	-						7
	<u> </u>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Use to (c	or as a consec	uence of):						
ď	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (d	or as a consec	uence of):					-	
8760.	ate be	dicai		d								
89 ×	certific Iding p	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo						23d. D	ate of deliv	ery
7.5 P.O. Box	that the death ed by the atter detached for u	Physician/M	in the past 12 months?  1  Yes 2 No 9 Unknown		nth 2 □ Feta ant at time of c wn		□Ectopic pregnar □ Other (specify)			1	fonth	Day Year
v	es ug	þ	Part II. Other significant condit	ons contributing to de	ath but not res	ulting in the	underlying cause (	given in Part I.		tobacco use con Yes 2 ☐ No		the cause of death? bably 4 20nknown
Record	aw as t	ompieted							perl	s an 24b opsy ormed? 2 No	prior to co death?	opsy findings available ompletion of cause of
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	3				26. Place of Dea				
\$ > 10	Phyaician: this certific ral director,	ToE	1 ☐ Yes 2 ☐NO					Other: 4 Nursing H				MHOSPICE
	ding P	on:	27. Manner of Death  1 Natural 5 Pend		f Injury n, <i>Day Year)</i>	28b. Time Injury	W	jury at /ork? □ Yes 2 □ No	28d. Describe	how injury occu	irred	
COVO	Attanding r death. actor: After by the fune	Certification:	3 Suicide 6 Could	mined 200. Flace	of Injury - At h	ome, farm, s	treet, factory, offic			(Street and Num	nb <b>er</b> or Rur	al Route Number,
مَ خَ	tafor safte al Dira	Cert	4   Homede	Dunaii	ig, etc. (Specia	·y/			Oily or 10	JWII, State)		
\$	To the Hospital or Attanding Phyaician: The within 24 hours after death.  To tha Funeral Diractor: After this certificate his completely filled in by the funeral director, page	edical		ng Physician: To the I Examiner: On the ba and mann	sis of examina					, date and place	and due t	to the cause(s)
	To the to the complex	Σ	29b. Signature and title of certifi	er N			_	S8303	7	29d. Date sign		
	0		Ma	en m	~)		D: 13					I .
	V		Adm J. Charle	es und Le	of death (Ite	her Es	B. Prilati	Alhmire	MD 2	1204		
	St Regist	ate rar	31. Date filed (Month, Day, Yea, MAR 2 3	2004 32 R	egistrar's Sign	ature	out					

				State of Maryland / Department of Health and Mental Hygie	2004	09115
	_			Registrar Continuate of Death Heg	. No.	03110
		Physicia	an	1. Decedent's Name (First, Middle, Last)  PATTERSON  2. Date of Death Month	Day Year	3. Time of Death  4:45A M
		/Medic		1000	18 2004	
	4	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Sinni Hospital of Boltimore Baltiwore CHY	4c. County of Death	1
W				The Many Indiana I Share I are the standard of the Indiana A His I have at Birth	0.0:46	nalogo (Chato a s Familia
7		uneral		5. Social Security Number 6. Sex 1 Months Days Hours Min. 56. Sex 1 Months Days Hours Min.	ear) 1929 Col	nplace (State or Foreign untry)
=	D	irector		Usual Residence of Decedent	0,1130 662	ORGIA
BE	land	Mo Til		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
,—	Магу	유명	ţō	MARYLAND N/A BALTIMORE CITY		1 ⊠Yes 2 □ No
2	the	r 28a	Director		. Citizen of What Cou	untry?
SON	d 21215-0036 filed within 72 hours after death with the Maryland	ot rygiene. event, the Medical Evant ret must be redified at	D D	1232 W. LAFAYETTE AVE. 1st Floor 21217	J.S.A.	
PS	deat	E L	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Amer Black, White	
TI	<b>6</b>	or ite	F	1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give 1 Yes 2 Mo Specify:		, etc.
F	<b>5-0036</b>		d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify: 3	LACK
PATTE	<b>5-(</b>	nato	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16 (Specify only highest grade completed) (Give kind of work done during most of working	6b. Kind of Business/li	ndustry
	the life	han han	mpl	Elementary/Secondary (0-12) College (1-4or 5+)  2 YFARS  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)		
53	21 Med will	her t				OVERNMENT
, 2	oue a	evar	Be	7001		LIAMS
-	Maryland 2121	narke natic	Lo			
Keeser	Maryland	r nearin and Mer item 27 is marke othar traumatic	W.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, C  SHALOM PATTERSON (DAVEHTER) 1832 W. LAFAYETTE AYE, 15TFL, B		
3	e, T	Department of nearin Important: If item 27 any injury or othar tra once.			c. Location - City or T	
	Baltimore,	or of				
Portieult	Lim Pa	tant:		1 □ Burial 2 🗷 Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  "2TRO CREMATORY 03 - 27-2004 B		
Žie.	Balt permit.	Deparment Important: any injury QDCe.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  3052PH H. BROWN JR. FUNE  3052PH H. BROWN JR. FUNE	IERAL HON	ne ne
Ga	<b></b> a.c	2 E 8 04		CONTRACTOR AND TOLICAL AND TOL	110001111-	
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.	4.	Approximate Interval Between Onset and Death
		ysician		Immediate Cause (Final disease or condition Aspiration Pneumonic		10 days
		ledical aminer		resulting in death)  Due to (or as a consequence of):		
	1	amme	_	Sequentially list conditions, b.		
,	W B	. Sie	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury		
	Secuted	and -tran	кат	that initiated events resulting in death) Last  Due to (or as a consequence of):		
	760,	attending physician and for use as the burial-transit				
		physi the b	dical			
	Records, P.O. Box 68 The law requires that the death certifica	ding I	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	and Date of della	
	Box eath cert	atten for u	ian	23b. Was decedent pregnant   1 Live birth   2 Fetal death   3 Ectopic pregnancy   4 Pregnant at time of death   5 Other (specify)	23d. Date of deliver Month	Day Year
	P.O.	the	ysic	1  Yes 2 No 9 Unknown		
	That	been signed by the attendin should be detached for use			cco use contribute to	the cause of death?
	ds,	sign d be	d by	Corrected Actes Diversity	2 □ No 3 □ Pro	bably 4 Unknown
	jo.	peed	ete	HIV With CD4 - 144 24a. Was an	Jah Word and	opsy findings available
	e law	S CI	Completed	PITO COLO OD TITO	prior to co	ompletion of cause of
	# # #	is certificate has director, page 2			No 1□Yes	2 No
	Vita	certif	Be	examiner?		
	of Vita Physician:	· 20	10	1 Unpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence		ify)
	DO ding	After funer	ion	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	anjury oddanied	
	Vision	deatl	ical	2 Accident investigation  3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street)	et and Number or Rur	ral Route Number.
	Division of Vital Records,	affer Dira in by	Certification:	determined determined building, etc. (Specify)		
	spital	ours neral filled			se(s) and manner as	stated.
	Hos	within 24 hours after death.  To the Funeral Diractor: After th completely filled in by the funeral	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date one)	and place, and due	to the cause(s)
	o th	vithin fo th iompl	Me	29b. Signature and title of certifier 29c. License number 29d	d. Date signed (Month,	, Day, Year)
		> = 0		> ABuquaus haité HA RES-000 Ma	itely 18	2004
		/	1		,	
	-	5			Baltimore	0
		Sta	ite	31. Date filed (Month, Day, Year) 4		
		Registr	ar	MAR & 3 LUUT		

PATTERSON, BETTYE

Department of the art of strong between the winners are used may rain be partment of the art of the	Usual Residence of Decedent  10a. State 10b. County  Maryland  10e. Street and Number  3816 Parkmont Avenue  11. Marital Status  1 Never Married 2 Married	Sex 1 M 2 XF	7. Age (In yrs	s. <i>last birthday)</i> Yrs. City, Town or Lo Ba <b>ltimore</b>	Timoniu	ar   If Under 24 Hi	s. 8. Date of Birth	4c. Coun Balt	Year  y of Death  more  9. Birthp	1:56 A
Examiner Funeral Director	Stella Maris Hospice  5. Social Security Number 212-28-9946  Usual Residence of Decedent  10a. State 10b. County  Maryland  10e. Street and Number 3816 Parkmont Avenue  11. Marital Status  1 Never Married 2 Married	Sex 1 M 2 XF	7. Age (In yrs	Yrs.	Timoniu	<b>IM</b> ar ∣lf Under 24 Hi	s. 8. Date of Birth	Balt	imore	laca (China
Director	5. Social Security Number 212-28-9946  Usual Residence of Decedent  10a. State 10b. County  Maryland 1  10e. Street and Number 3816 Parkmont Avenue  11. Marital Status  1 Never Married 2 Married	Sex 1 M 2 XF	75 10c. C	Yrs.	Months Day			Year)	9. Birthp	lana /C+++ ==
natural; or liema 23a or 28a-f ehow dical Examinar must be notified at eted by Funeral Director	10a. State 10b. County Maryland 1 10e. Street and Number 3816 Parkmont Avenue 11. Marital Status 1 Never Married 2 🛣 Married				cation			1928	Mary	lace (State or Fore try) and
natural; or liema 23a or 28a- dical Examires must be notifi eted by Funeral Direct	10e. Street and Number 3816 Parkmont Avenue  11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	12 Was Dos							1	0d. Inside City Lim
natural, or itema 23 dical Examiner mus eted by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12 Was Dos			10f. Zip Code 21206	)		10g. Citizen of	What Cour	itry?
oleal E		Armed F 1 Tes If Yes, G Year or I	2 ሺ No ve	l	Was Decedent of	uban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Ra	ice - Amend ack, White,	etc.
ygiene. Ne than *natur. 1, the Medical I	15. Decedent's (Specify only highest g	Education rade completed, NA	1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use ret	ne durina most of w	orking	16b. Kind of I		lustry
Mental Hygi arked other atic event, I	17. Father's Name (First, Middle, Las	it)					ame (First, Middle, e Crispens	Maiden Suma	me)	
Health and N em 27 is mai	19a. Informant's Name/Relationship Stanley N. Petr/Husb			381	.6 Parkmor		Rural Route Numbe Baltimore Ma		, State, Zip 21206	Code)
ment of He ant: If item ury or oth	20a. Method of Disposition  1 🔀 Burial 2 □ Cremation 3  1 □ Other (Special Control of C	24.A	State Ceo	dar Hill	natory or other p Cemeterv	3,	Date /24/04	20c. Location Brookly		wn, State Maryland
Department of Important: If any injury or once.	21. Signature of Funeral Service Lice	ensee Chris	tina L. 1 Iton	Hilton 28	onard J. 05 Harfor	Ruck, Inc. d Road Ba	timore Mary	/land 2	1214	
physician and street in the buriah-transit i	disease or condition resulting in death)  Sequentially list conditions, taken the conditions, taken the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to  Due to	(or as a conse	equence of):	ACCIDEN					
ed by the attending phydelached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1 Live	tcome of pregr birth 2 Fet nant at time of own	tal death 3	Ectopic pregnar Other (specify)	ncy			ate of delive	ry Day Year
be of <b>d</b>	Part II. Other significant conditions	contributing to c	eath but not re	sulting in the un	nderlying cause	given in Part I.	11	_		e cause of death?
cate has been s page 2 should Completed							24a. Was a autops perform	iy .		psy findings availa npletion of cause of
this certificate al director, pag To Be Co	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No			∃ER/Outpatient	1 3□ DOA C	M	eath <i>(Check only on</i> Home 5 Reside		ner (Specity	HOSPICE
rector: After rector: After by the funer tification;	27. Manner of Death  1 XNatural  2 Accident  3 Suicide  4 Homicide  5 Pending investigate 6 Could not determine	on be 28e. Place	th, Day Year)	28b. Time of Injury nome, farm, streatfy)		fork? ☐ Yes 2 ☐ No	28d. Describe ho	reet and Num		Route Number,
within 24 hours afte To the Funeral Dir. completely filled in I	29a. Certifier (Check only one)	hysician: To the	best of my kn	owledge, death	occurred at the	time, date and place	e, and due to the caurred at the time, d	ause(s) and m	anner as sta	ated. the cause(s)
within 2 To the complet	29b. Signature and title of certifier	and man	ner stated.			nse number		9d. Date signe		

1:56 a.m.

MARCH 21, 2004

MARGUERITE PETR

		1	For State Registrar	State of Mar		artment of H			ene J. No. 2004	09117
	Physicia	an	Decedent's Name (First, Middle HUGH		E PAGON			2. Date of Death Month March 21	, <sup>Day</sup> 2004 Year	3. Time of Death 12:30P M
39	/Medic Examin		4a. Fecility Name (If not institution			4b. City, Town, or	Location of Deat	ו	4c. County of Death	
			11 Dev	on Hill Road			imore	O Contract Birth	Baltimo	
	Funeral Director		5. Social Security Number 219–18–6716	90	(In yrs. last birthday) 81 Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, 1 February 1	4,1923 Mary	place (State or Foreign ntry) / I and
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f sh	ctor	Maryland Baltin	more	Baltimore					1 □ Yes 2 No
	h with the	al Director	10e. Street and Number 11 Devon Hill	Road B9		10f. Zip Code 212	10	109	g. Citizen of What Cou USA	intry?
36	within 72 hours affer death with the Maryland ene. then 'ratural', or items 23a or 28a-f show then hadical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Nøver Married XXX Marri 3 □ Widowed 4 □ Divorced	IT YAS, LIVE	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes XX No	ispanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: Win	, etc.
Maryland 21215-0036	ithin 72 house.	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12)	nt's Education st grade completed)  College (1-4or 5+	(Give	edent's Usual Occupa a kind of work done of DO NOT use retired	during most of wo	rking	6b. Kind of Business/I	ndustry
121	be filed within fal Hygiene. od other then event, the Me		17. Father's Name (First, Middle,	Last)	Inves	tment Analys		me (First, Middle, Ma	Finance aiden Sumame)	
land	<b>₽</b> ₩ ₩ ₩	To Be	William Waters				Kathar	ine Wrigh	t Dunn	
_	nd 2 sh alth and 27 is rr ir traum		19a. Informant's Name/Relations Caroline S Pago 20a. Method of Disposition	n Wi	fe 11 D		Road B9	Baltimor	City or Town, State, Zi e, Marylan Oc. Location - City or T	d 21210
Baltimore,	permit. Pages 1 a Department of Hec Important: If Item any injury or othe		XX Burial 2 ☐ Cremation 4☐ Donation 5 ☐ Other (S 2) A gnature of Funeral enrice	Specify) Ligensee	Greenmou	nt Cemete	ry 3/2 ss of Facility Mi		feld Funeral	
8	8818		23a. Part1. Enter the disease, o		be death. Do not as	tor the made of duin			imore, Maryla	Approximate
3760,	Physician /Medical Examiner and physician and physician and the price for the price of the price	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PCM & Due to (or as a	consequence of):  Consequence of):  Consequence of):  Consequence of	spiro flur hriki phro	e a sai	zote nd di		Onset and Death
.O. Box 68	Physician: The law requires that the death certifical riths certificale has been signed by the attending phraid director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	2 ☐ Fetal death 3	☐ Ectopic pregnancy	,		23d. Date of delifi Month	very Day Year
٩	w requires fhat to be been signed by should be detailed		Part II. Other significant conditi	ions contributing to death bu	t not resulting in the	/	SPARC		accoluse contribute to	3.6
Division of Vital Records,	sician: The law req certificafe has beer irector, page 2 shou	Completed by	Lion	- with	sto	ht_		24a. Was an autopsy perform	24b. Were au prior to death?  X No 1 Yes	topsy findings available completion of cause of
/ita	cian: ertifica	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only one		
on of \	fing After fune	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	28a. Date of Injun	nt 2 ☐ ER/Outpati y Year) 28b. Time Injury	of 28c. Injur		Home 5 Resider 28d. Describe how	nce 6 □Oth <i>er (Sp</i> ec w injury occurred	ufy)
Divisi	or Attendii atter death. Director: Al	Certification:	3 Suicide 6 Could	d not be mined 28e. Place of Inju building, etc	ry - At home, farm, s . (Specify)	street, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the best of I Examiner: On the basis of and manner sta	examination and/or	ath occurred at the ti investigation, in my o	me, date and place opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certific	of Schu	um,	AD DO	60107	75 29	od. Date signed (Month	Day, Year)
-	6		30. Name and address of person		eath (Item 23a) (Type 3 0 (ECL.	e, Print)	suik	0 281	, Bal	timore
ē	St Regist	ate trar	31. Date filed (Month, Day, Yea MAR 2 3 2		ar's Signature	Louke	· ·			

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State o	f Maryl	and / Depa	artment o	of Health of Deat	and M	ental Hy	giene Reg. No.	2004	09118
	Physicia		1. Decedent's Name (First, Middle, La							2. Date of De Month March		Year Year	3. Time of Death
	/Medic	al	CAROLYN KRAFT  4a. Facility Name (If not institution, given	PILACH			4h Cihi Tou	vn, or Location		March		County of Death	8:10P M
	Examin	er	Gilchrist Cente		ino <del>a</del> rj		Tows		1101 20411			Baltimo	
	Funeral		5. Social Security Number 6.5	Sex	-	yrs. last birthday)	If Under 1 Y Months Da	ear If Und	er 24 Hrs. Min.	8. Date of Bi (Month, D) January	rth	9. Birth Cou	place (State or Foreign Intry) Cyland
	Director		219-10-1353 Usual Residence of Decedent	1□ M 2\XF	79	Yrs.			·	January 7	20,192	5 Mai	ryland
	yland Now		10a. State 10b. County		10c	. City, Town or Lo	ocation				-		10d. Inside City Limits
	e Man	ctor	Maryland Baltim	ore	В	altimore							1 ☐ Yes XX No
	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23s or 28s-f show any njury or other treumatic event, the Medical Examinat must be notified at once.	Funeral Director	10e. Street and Number 8403D Nunley Dri	ve			10f. Zip Co 2	1234				uSA	
	tams	uner	11. Marital Status	12. Was Dec Armed Fo	orces?	in U.S. 13.	Was Decedent If Yes, specify	of Hispanic ( Cuban, Mexic	Origin? (Spe can, Puerto f	cify Yes or N Rican, etc.)	0- 1	<ol> <li>Race - Amer Black, White</li> </ol>	
36	irs afte	by F	1 ☐ Never Married 2 ☐ Married  XX Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gr Year or D	ve Dates:		¹□Yes XX	No Speci	ty:			Specify:	White
2-0	72 hou	sted	15. Decedent's E (Specify only highest gi	ducation		16a. Dece	dent's Usual O kind of work of DO NOT use n	ccupation fone during m	ost of working	ng	16b. Kir	nd of Business/I	ndustry
21	han "	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	Homema				1	Own Home	ے
d 21	filed w Hygiel ther t		17. Father's Name (First, Middle, Las	t)			Homema		ther's Name	(First, Middle			
an	lid be lental rked o	To Be	Charles Henry Kr	aft				М	aria k	Kreusir	nger		
<u>a</u> ry	2 shou and M is mai		19a. Informant's Name/Relationship									Town, State, Z	
Ø, ₹	and sealth		Frank M Pilachow	ski Jr	Sc	on 8 Lai				nore, N		and 212:	
2 5	ages 1 nt of H t: If ite / or ot		20a. Method of Disposition  X			cometery, cre Most Holy	matory or other	r place)	3/24/			_	Maryland
$S \in \mathcal{S} \cap \mathcal{PM}$ Baltimore, Maryland 21215-0036	ermit. P epartme nportani ny njury nce.		4 □ Donation 5 □ Other (Spec 21 Signature of Funeral Service Lice	ensee	a hi	`		Address of Fac			edefe1	d Funeral	Home Inc.
(g <u> </u>	205 29		23a, Part 1. Enter the disease, or cor		and the	death. Do not en	ter the mode of					e, Maryla	Approximate
~			shock, or heart failure. List only Immediate Cause (Final	y one cause on	each line.	1	Bres	_					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to	(or as a cor	atm Tic nsequence of):	Tyles	ast C	RUCE	:/(			gears
0	Examiner		Sequentially list conditions.	b									
3	is in	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a cor	Ізецивнов оі).							
+ -	al-tran	Examiner	that initiated events resulting in death) Last	c Due to	(or as a cor	rsequence of):							
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MAH Box 68	entifica ing ph e as th	Med	IF FEMALE:										
^ Bo,	death certifical e attending phi id for use as th	lan/	23b. Was decedent pregnant in the past 12 months?		itcome of pr birth 2 nant at time	Fetal death 3	□Ectopic pregr				2	23d. Date of deli Month	very Day Year
-0	the de	hysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unkr									
HOWSK ecords, P	The law requires that the death certifical to has been signed by the attending phy age 2 should be detached for use as the	d by Physiclan/Med	Part II. Other significant conditions	contributing to	death but no	t resulting in the i	underlying caus	se given in Pa	irt I.				the cause of death?
CHOW Record	s beer s beer s shou	Completed								24a. Wa	s an opsy	24b. Were au	topsy findings available completion of cause of
S E	The la	omb								perf	formed?	death?	2□ No
LA ital	cien: ertifică actor, l	Be	25. Was case referred to medical examiner?	(Janaital)	-					(Check only			//-
a fo	Physicien: this certific ral director,	-T	1 ☐ Yes 2 No 27. Manner of Death			2 ER/Outpatie				me 5 🗌 Res 28d. Describe		Other (Spec	sity) (tospice
7.0	tending leath. tor: After the funer	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigate		of Injury oth, Day Yea	ar) Injury	М	Injury at Work? 1 ☐ Yes 2			,	,	
S	l or Atter after dea Director	Certification:	3 Suicide 6 Could not determine	289. Plac	e of Injury - ding, etc. (S	At home, farm, si	treet, factory, o	ffice			(Street and own, State)		ral Route Number,
CAROLY	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.		(Check only 2 Medical Ex	aminer: On the	basis of exa	y knowledge, dea mination and/or i	th occurred at to	the time, date	and place, a	and due to the	e cause(s) e, date and	and manner as	stated. to the cause(s)
U	To the I within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and mai	nner stated.			icense numbe			29d. Date	e signed (Monti	n, Day, Year)
	To To		1 Thatha	my Kw	les.	ung	De	25 Di	25		MA	vch 21	, 200x
_	5		30. Name and address of person wh	1/10	ise of death	(Item 23a) (Type	, Print)	· St	Belt:	). Md	2	21204	, 2004
	Str	ate	31. Date filed (Month, Day, Year)	32.	Registrar's		,		. ,				
	Regist		MAR 2 3	2004	Papir	me by	Spo	ules	<b>₩</b> .				

			1 - For State Registrar	State of Mar	yland / i		nent of H		d Mental Hy	giene Reg. No. 2	006	19119
	Physic /Medi		Decedent's Name (First, Middle, Last)     Earl Glenroy Ric						2. Date of De Month March	19 2	Year 2004	3. Time of Death 12:30 A.M
	Examir	ier	4a. Facility Name (If not institution, give s  Haven Homes  5. Social Security Number 6. Sex		In yrs. last bii		nder 1 Year	. Airy	Hrs. 8 Date of Bi	(th	nty of Death Carrol	
M.	Funeral Director		703-07-9878 183 Usual Residence of Decedent	IM 2□F	84	Yrs. Mor	iths Days	Hours N	Min. (Month, D. March	22 <b>,</b> 19	19 Ma	place (State or Foreign ntry) ryland
	the Marylar 28a-f show	Director	10a. State		Oc. City, Tow	rland	f. Zip Code			10g. Citizen o		1 ☐ Yes 2 ☒ No
	3a or		14501 Smouses R	oad			21502				d State	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itema 23a or 28a-f show sty injury or other traumatic event, the Medical Examination to the traumatic event, the Medical Examination to 11 and 1200.	by Funeral		12. Was Decedent Ev. Armed Forces? 1 [X] Yes 2 □ No If Yes, Give Year or Dates:	er in U.S.				? (Specify Yes or No uerto Rican, etc.)	o- 14. R	Race - Americ Black, White, cify: White	ean Indian, etc.
1215-0	within 72 ho ane. then natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th		16a	(Give kind o life. DO No	Usual Occupa of work done of OT use retired, Owner	uring most of	working	16b. Kind of	Business/Ind	dustry
Maryland 21215-0036	uld be filed Aental Hygie rked other tic event, tr	To Be Co	17. Father's Name (First, Middle, Last)  Alonzo Glenroy	Rice			wiiei		Name (First, Middle			pply Co.
, Mary	and 2 shousalth and N 27 is ma		19a. Informant's Name/Relationship (Type Robyn Roland	oe, Print) daughter					r Aural Route Numb t. Airy,	-		Code)
Baltimore,	Pages 1: ment of He tant: If iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)			ry, crematory	(Name of or other place Cemete:		Date cch 22, 20		n·City or To mberla	
Ball	Depart Depart Import eny in		21. Sighatul of Fir ral Service License	Call		Burr 1212		een Fur d Liber	neral Directy Road		P.A.	21784
8760,	Physician and physician and physician and physician and the printing in the pr	edical Examiner	23 Part1 Enter the disease, or complic shock or heart failure. List only on line in Cause (Final disease) are condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	idney (	Cancer of): of):	mode of dying	, such as can	иас от геориалогу а	rrest,		Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be execuled tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tirn 9 ☐ Unknown	∃Fetal death		ic pregnancy r (specify)				Date of delive	ry Day Year
	quires that In signed by Ind be deta	by	Part II. Other significent conditions con	tributing to death but r	not resulting in	n the underly	ng cause give	n in Part I.		_		e cause of death?
Division of Vital Records,		e Completed	25. Was case referred to medical					00 Bloom 44	1 Yes	osy ormed? 2 X No	prior to con death?	psy findings available in pletion of cause of 2 No
>		0 B	examiner?	ospital:	2□ER/Ou	tpatient 3	DOA Othe		Death <i>Check onl</i> of g Home 5⊠Resi		ther (Specify	()
ion o	ding After	atlon: T	27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y		Time of njury	28c. Injury Work	at ? es 2 □ No	28d. Describe			
<u>Š</u>	ital or Attendirs after deathral Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	- At home, fa Specify)	rm, street, fa	ctory, office		28f. Location ( City or To		nber or Rural	l Route Number,
	To the Hospital within 24 hours or To the Funeral or completely filled	ledical	29a. Certifier 1 Tay Certifying Phys (Check only one) 2 Medicel Exemin	ician: To the best of n ler: On the basis of ex and manner stated	amination an	e, death occu d/or investiga	rred at the timi ition, in my op	e, date and plainion, death o	ace, and due to the courred at the time,	cause(s) and r date and place	manner as sta e, and due to	ated, the cause(s)
)	To the within 2 To the complet	×	29b. Signature and title of certifier	Beo,	, mo		29c. License	number 57/		29d. Date sign	ned (Month, E	
0	+1		30. Name and address of person who cor Dr. Truong Bao	mpleted cause of deat 13219 Exect								
	Sta Registr	-	31. Date filed (Month, Day, Year)  MAR 2 3 201	32. Angistrar's	Signature	him	4 p					

ORIGINAL

			For State Registrar	State of Man		artment of rtificate of		nd Mental Hy	giene Reg. No. 2004	09120
	Physicia /Medic			oseph A.	Reite			2. Date of De Month	Day Year 18 2009	3. Time of Death $15/55\mathrm{PM}$
	Examin Funeral Director		5. Social Security Number 6. S 215-30-3294	LARE HOS	h yrs. last birthday) 70 Yrs.	4b. City, Town,  Rose If Under 1 Yea Months Day:	A/e If Under 2	4 Hrs. 8. Date of Bi	rth 9. Birt	MCRE  hplace (State or Foreign  cyland
	Maryland f ehow	or	Usuat Residence of Decedent  10a. State 10b. County  MD Balti		Oc. City, Town or Lo	Essex				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	death with the Maryland ma 23a or 28a-f ehow r. must be notified at	I Director	10e. Street and Number 1000 Frankl	in Ave		10f. Zip Code	21221		10g. Citizen of What Co	untry?
5-0036	or Ite	by Funeral	11. Marital Status  1 ☐ Never Married 2  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 TYYes 2 □ No If Yes, Give Year or Dates:			Hispanic Origi iban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)		e, etc.
21215-0	72 ho	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 10th		16a. Dece (Give life. Plur	dent's Usual Occ kind of work don DO NOT use retii nber	upation e du <i>ring m</i> ost o red)	of working	16b. Kind of Business/BarnsConst	Industry tructionCo
Maryland	should be filed and Mental Hygic marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last, Edward A. Re					s Name <i>(First, Middle</i>		
altimore, Man	jes 1 and 2 sh of Health and if item 27 is m or other traum		19a. Informant's Name/Relationship ( Elizabeth Rei 20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Special	ter /wife	10( 20b. Place of Dispo cemetery, cre HollyHi	00 Fran osition (Name of matory or other p. 11 Ceme	klin A	Ave. Apt1 B/22/04	201Baltim 20c. Location - City or Baltimore	©eMD21221 Town, State e MD
Ball	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licer  23a. Part 1. Enter the disease of comshock, or heart failure. List only	Connell	y		ace Av	<u>re. Balti</u>	FuneralHomore MD 2	
8760,	Physician and Medical Examiner and Physician	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causa. Lifest of Joshyka gray that initiated events resulting in death) Last	a. Due to (or as a co	onsequence of):	ng C				Interval Between Onset and Death
.O. Box 6	that the death certificate ed by the attending physi detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of p 1 Live birth 2 [ 4 Pregnant at tim	]Fetal déath 3 [	Ectopic pregnan			23d. Date of deli Month	very Day Year
4	Se Co	by	Part II. Other significant conditions of	contributing to death but n	ot resulting in the u	nderlying cause ç	given in Part I.	23e. Did	tobacco use contribute to Yes 2 □ No 3 □ Pro	the cause of death?
Vital Records,	e law r has be je 2 sh	Completed						24a. Was auto perfo	an psy prior to death? 2 XNo 1 □ Yes	topsy findings available completion of cause of
Vita	ician: certific rector,	o Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	2 ER/Outpatie	- 2 DOA C	hh ac	of Death (Check only		
ion of	fter free	$\vdash$	27. Manner of Death  1 Salatural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. In	4 🗀 Nurs	28d. Describe	dence 6 Other (Spec how injury occurred	nry)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		- At home, larm, st Specify)	reet, lactory, office	e	28f. Location ( City or To	Street and Number or Ru wn, State)	ral Route Number,
	To the Hospi within 24 hour To the Funer completely fill	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	nysician: To the best of n niner: On the basis of ex and manner stated	amination and/or in	vestigation, in my	opinion, death	occurred at the time,	date and place, and due	to the cause(s)
	To the within To the Comp	Me	29b. Signature and tribe of certifier	1		29c. Lice	nse number	000	3/18/0	Day, Year)  4  Md 21237
	5		30. Name and address of person Tho  DR. Ebour STAA	1/21/2 T.11.	(Item 23a) (Type.	Print) RANKI	in Squ	ARE DR.	BAITIMORE	Md 21237
>- 	Sta Registi	ite ar	31. Date liled (Month, Day, Year)	32. Polistrar's	Signature .	books	C			

DHMH 17 Rev 1/2001

Joseph ReiTeR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Deeth osP, to 50 .05 P 04 do 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min Year 10 M 2□ F Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ortant: If Item 27 is marked other than "natural", or itema 23s or 28s-1 show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits MARYLAND Director 1 ☐ Yes 2 📈 No TIMORE ARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 356 NGANORE AVENUE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Decedent Ever in U.S. 17 Yes 2 □ No 17 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced KOREAN natural 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 is marked o ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) VE. MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cometery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) EMETERY! 26,200 21. Signature of Funeral Service 22. Name and Address of Facility VANS SOCO HARFORD Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and thed for use as the buriat-transit the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9□ Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b Completed 1 🗌 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 1 Yes 2 No Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 3□ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After To the Hospital or Attanding 5 Pending 1 Natural investigation 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature e of certif 29c. License number 29d. Date signed (Month, Day, Year) INT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Baltimoré,

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

5940 re

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** March 20, Helen Α. Schuessler 04 11:45 A<sup>M</sup> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore 600 Light Street Apt. If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2√2 F New York Director 096-12-1980 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ahow the Medical Examiner mant be notified at Yos 2 No Baltimore Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Itams 23a or United States 21230 Apt. 518 600 Light Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Marned White "natural", or 1 ☐ Yes 2 € No Baltimore, Maryland 21215-0036 Specify: Yes, Give ear or Dates: Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tailor Clerk 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event size. 17. Father's Name (First, Middle, Last) Be Jane O'Connor Nicholas Mollitor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 108 Lassiter Circle Finksburg, Maryland 21048 Ethel Tilden - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 € Cremation 3 ☐ Removal from State 3/23/04 \* 4 Donation 5 Dother (Specify) Balt. Wash. Crematory Laurel, Maryland 21. Signature of Funeral polyipe License 22. Name and Address of Facility
Bradley-Ashton-Matthews Funeral Home, Inc.
2134 Willow Spring Road Dundalk, Maryland 21222 Wille Approximate Interval Between Onset and Death 23a. Part 1. Enter In . - ase, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can be on as in line. Immediate Cause (Final disease or condition resulting in death) 30 Physician Artherosc 2419 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 225 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown The law requires that the been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à ed bluods 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA SResidence 6 Other (Specify) Certification; To Sid 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred funeral 28b. Time of 1 ☑ Natural 2 ☐ Accident 5 Pending Injury 1 Yes death. investigation within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at the time. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 2004 D6033897 22, 2. LMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Ave Ballimar Robert MD 3509 Vissin 82. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 3 2004

7717	
State of Maryland / Department of Health and Mental Hygiene 2004	

		1 - State AMEND ITEM #20  1. Decedent's Name (First, Middle, Las					2. Date of D			3. Time of Death
sici		Gertrude Simp	son				March	Day 14	, 2004 <sup>Year</sup>	9:15 A
	al er	4a. Fecility Name (If not institution, give			4b. City, Tow	n, or Location of	Death		. County of Deal	
		Washington Advent	ist Hospital	1.	Takom	a Park		Me	ontgome	ry
		243-46-4725	7. Age (In ☐ M 2☐XF 7.	yrs. last birthday) Yrs.	If Under 1 You Months Da		Hrs. 8. Date of B (Month, D Dec. 3	rth ay, Year) ,192	9. Birt Co No:	thplace (State or Foreig buntry) rth Carolin
		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation					10d. Inside City Limit
	to	D.C.		Washing	ton					1 TyYes 2 □ N
	Director	10e. Street and Number			10f. Zip Cod	le		10g. Citi	izen of What Co	puntry?
		3929 Georgia Aver	nue, N.W.		200	11			US	A
	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	in U.S. 13.	Was Decedent If Yes, specify (	of Hispanic Origin Cuban, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ame Black, Whit	
	by F	1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give		1□ Yes 2□X	No Specify:				lack
		15. Decedent's Edi	Year or Dates:	16a Dece	dent's Usual Oc	cunation		16b Ki	ind of Business/	
	Completed	(Specify only highest grad	de completed)	(Give	kind of work do DO NOT use re	one during most of tired)	of working	100.10	ind of business	industry
	EO	12	College (1-4or 5+)	Hom	emaker			P	rivate	
	Be	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middle	, Maiden	Sumame)	
	10	Bert Anna (?)				Less	y Atkinso	n (?)	)	
	/ 6	19a. Informant's Name/Relationship (T Demetrius Reid - (		19b. Mailii 1342	ng Address (Str Talbert	Terr.,	or Rural Route Numb SE, Washin	er, City o 1gton	, DC 20	Zip Code) 020
		20a. Method of Disposition	20	b. Place of Dispo	sition (Name o	place)	Date	20c. Lo	ocation - City or	Town, State
		1 ☐ Surial 2 ☐ Cremation 3 ☐ 1 `4 ☐ Denation 5 ☐ Other (Specify,		aryland			3/20/04	Lau	rel, MD	
		21. Signature of Fureral Service Livens	500 / /	22	2. Name and Ad	Idress of Facility	Latney's	Fune	ral Hom	e
		Ja. Part1. Enter the disease, or composhock, or eart failure. List only of	lleum	38	31 Geor	gia Ave	.,NW, Wash	ingt		
	cal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneumonia  Due to (or as a con  Due to (or as a con  Due to (or as a con	sequence of):						
	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 23c. If yes, outcome of pre 1	etal death 3 cof death 5 c	Ectopic pregna Other (specify	)		2	23d. Date of deli Month	very Day Year
	þ	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause	given in Part I.				the cause of death?  bably 4 KiUnknov
Ì	Completed						24a. Was auto perfo 1 Yes	psy prmed?	death?	topsy findings availal completion of cause of
	Be	25. Was case referred to medical examiner?	Hospital:	_		Other	Death (Check only			
l	. To	1 Tes 2 No	1 Mapatient 2	2 ER/Outpatien 28b. Time of	3 DOA	4 Nursi	ng Home 5 ☐ Resi 28d. Describe			eify)
	itlon	1 XNatural 5 ☐ Pending investigation	(Month, Day Year	r) Injury	M	Work? ☐Yes 2☐No		now injury	y occurred	
	S	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecify)			City or To	wn, State)	)	ral Route Number,
	Certification:			knowledge, death	occurred at the	time, date and p	place, and due to the occurred at the time.	cause(s) date and	and manner as place, and due	stated. to the cause(s)
		29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sicien: To the best of my iner: On the basis of exam and manner stated.	nination and/or inv	vestigation, in m	y opinion, dozur				
	Medical Certifica	(Check only 2 Medical Exam)	iner: On the basis of exam	nination and/or inv		ense number			e signed (Month	
	edical	one)	iner: On the basis of exam	nination and/or in		ense number		29d. Date		, Day, Year)

			i icase	State of Maryland	/ Denartme	ent of Health and	Mental Hygien	e e e -	
			1 - For State Registrar	Clair of Maryland		ate of Death	Reg. N	20114	09124
	Physici		1. Decedent's Name (First, Middle, Las	SuLLi	VAN		2. Date of Death Month D	12, 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. C	ty, Town, or Location of Deal		ic. County of Death	
	Funeral	1 (4)	5. Social Security Number 6. S.	TAN TOS	orthogy) If Un Monti	der 1 Year If Under 24 Hrs Is Days Hours Min.		9. Birthpla Countr	ace (State or Foreign
Ī,	Director		Usual Residence of Decedent	M 2□F 85	Yrs.	Says Hours I	MAY 24,1	918	MD.
1	show Mal		10a. State 10b. County	10c. City,	Town or Location		<i>y</i>	100	d. Inside City Limits
2	Ba-fs	Director	MD. NA	BA		RE			1 Nes 2 No
	Reme 23a or 28a-f shov	Dire	10e. Street and Number	in PD	10f.	Zip Code	10g. C	Citizen of What Countr	y?
1	me 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - America Black, White, et	
350	tural', or its	þ	Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 M No If Yes, Give Year or Dates:		2) No Specify:	to riteati, oto.,	Specify: W	HITE
		Completed	15. Decedent's Ec (Specify only highest gra		16a. Decedent's U (Give kind of	work done during most of wo	rking 16b.	Kind of Business/Indu	ıstry
121	than "na	Junc	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	SABLED		NA	
	tal Hygi d other svent, I	Be Co	17. Father's Name (First, Middle, Last)	• 1		18. Mother's Na	me (First, Middle, Maide		
		ToE		KNOWN			UKNOW		2000
Mary	trat		19a. Informant's Name/Relationship (	TYPE PRINTIFIELD NOTES		ess (Street and Number or R	ural Route Number, City	or Town, State, Zip (	2120i
ē,	of Heal of Heal fitem		20a. Method of Disposition	20b. Pla	ace of Disposition (i	Name of prother place)	Date 20c.	Location City or Tow	m, State
altimore,	ment of ment of lent: If it		1 Burial 2 Cremation 3 C 1 Donation 5 Other (Specify	1) 110	LY TRIN		2004 B	ALTO-14	D ·
Ba	Departiment in any in once.		21. Signalure of Foreral Service Licen	Skarda	22. Name	AM Address of Facility	2829 HU	MD. 212	24
			23a. Part1. Enter the disease, of comshock, or heart failure. List only	plications that caused the death.	Do not enter the n	node of dying, such as cardia		í	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)	. ASPINAT	ton pr	Umonic		1	Onset and Death
	/Medical Examiner			Due to (or as a consequence	ence of):	Sensos		,	David
*	. =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):				
	ysicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseque	ence of):				1.52
760	ysicien ysicien	caiE		d					
		an/Med	IF FEMALE:						
Вох	e attending phod for use as the	clan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan  1 Live birth 2 Fetal ( 4 Pregnant at time of deal	death 3□Ectopi	pregnancy (specify)		23d. Date of delivery Month	y Day Year
		Physica	1 ☐ Yes 2 2 No 9 ☐ Unknown	9☐ Unknown					
ds, F	the has been signed by the vage 2 should be detached	þ	Part II. Other significant conditions of	ontributing to death but not resul	ting in the underlyin	g cause given in Part I.		o use contribute to the	cause of death?
Records,	s beer 2 shou	Completed					24a. Was an autopsy	24b. Were autops	sy findings available pletion of cause of
_	10 7	Com					performed?	death?	
Vital	r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other:	ath (Check only one)		
ō	eral di	n: To	1 ☐ Yes 2 No 27. Manner of Death		28b. Time of	DOA 4 Nursing I	dome 5 Residence 28d. Describe how in		
Sion	Attending Frigstoran. r death. ector: After this certific by the funeral director.	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1	Injury M	1 Yes 2 No			
Division	ater death. I Director: After I	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, fac	tory, office	28f. Location (Street a City or Town, Sta	and Number or Rural i ite)	Route Number,
:	ons nospietoralismos within 24 hours after of To the Funeral Direct completely filled in by the second complete of the following the second complete of the seco	edicai C	29a. Certifier Certifying Ph	ysician: To the best of my knowniner: On the basis of examination and manner stated.	vledge, death occurr on and/or investigat	ed at the time, date and plaction, in my opinion, death occ	a, and due to the cause urred at the time, date a	(s) and manner as stated	ted. he cause(s)
:	Multhin To the	Me	29b. Signature and title of certifier			29c. License number	29d. D	ate signed (Month, Di	ay, Year)
	Λ		* Klean	MX		D 233	71	3-15	-2004
	/		30 Name and address of person who \$60	completed cause of death (Hear	23a) (Type, Print) WCW	29c. License number D253 Alvd, Ba	Mimore	mo 21	239
	Sta Regist	ate -	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	le hon	e Kal			

State of Maryland / Department of Health and Mental Hygiene 2004 09125 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 16, 2004 12:10 a M March Paul Tyler Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens Silver Spring Prince George's If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1□M 2□F Yrs Apr. 1916 Maryland 217-10-3536 87 Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 ☐ No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3126 Gracefiled Road Apt. BG205 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Bleck. White, etc. ty⊡rYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes ŽÍŽNo Specify: White Completed by 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Govt. permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "nu any injury or other traumatic event, The Meulis once. Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) (GOA) Transportation Specialist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Paul Smith Edith G. Tyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 525 Powers Court Avenue Alpharetta, GA Tyler Smith son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Surial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Church Cem. 3/19/2004 Fulton, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** Advanced Parkinson's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner End Stage Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pressure Ulcer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → Yes Malnutrition 24a. Was an performed?. 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XX 3□ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Puthumana D59524 March 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loveen Puthumana , M.D. 3110 Gracefield Road Silver Spring, Maryland 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 2 3 2004 Registrar

DHMH 17 Rev 1/2001

**Funeral** 

Director

Item 27 is marked other then "natural", or items 23e or 26e-4 show other traumatic event, the Medical Examiner must be notified at

death with the Maryland

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death certificate be executed

P.O. Box 68760,

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Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hydiene 1 - For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 21 5:10 A.M March 2004 Noel Benjamin Simpson /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Oakland Manor Nursing Home Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min 9. Birthplace (Stete or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** Months 1 X M 2 □ F 82 1921 326-16-5215 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Carroll Sykesville Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2810 Kaywood Place 21784 United States Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ₩ Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Crane Operator Arundel Crane Co. 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Simpson Xava Nunn 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i 229 Sudley Lane Edna Miller Stepdaughter Martinsburg, West Virginia 25401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Meadowridge Mem. Park March 25, 2004 Elkridge, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Directors, PA 21. Signature of Funeral Service Licensee 21784 1212 W. Old Liberty Road Sykesville, MD Pent | Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final disease or condition **Physician** how /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANCH RA GLEN BURNIE MA RUBEN REIDER FURNACE 32. Regiswar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 MARCH 18 8:45 PM SKOTARSKI MARION /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1√ M 2□ F Months Days Hours Yrs. 79 219-14-0751 18, 1924 Maryland **Director** Usual Residence of Decedent pamit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No Directo Maryland Queen Anne's Centreville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 501 Watson Road 21617 Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 1X Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Carpenter 10th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Sigai John Haus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 501 Watson Road, Centreville, MD Mrs. Julia Skotarski (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremetion 3 □ Removal from State ŏ 4 ☐ Donation 5 ☐ Other (Specify) 3/22/04 Baltimore, Maryland Injury Sacred Heart of Jesus 22. Name and Address of Fecility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Bactimore, MD 21236 23 Fart1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical SEIZURE DISORDER Examiner Medical Certification: To Be Completed by Physician/Medical Examiner CEREBLOVASCULAR INSUFFETENCE Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 or Attending Physician: The law raquiras that the death cartificate be Due to (or as e consequence of): ONITY Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ALHEIMERS TYPE 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Director: After this cartificate I 1 Tyes 2-1NO 1 ☐ Yes 2 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 48 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 Naturel 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di complataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ed cause of death (Item 23e) (Type, Print) 30. Neme and address of person who comple M.D., 2540 CENTREVILLE ROAD, CENTREVILLE, MD 21617 ERIC R. CIGANEK,

**DHMH 16 Rev 6/95** 

Registrar

31. Dete filed (Month, Day, Year)

MAR 2 3 2004

32. Registrar's Signature

	1- For State of Maryland / Department of Heal Certificate of De	, 0
Physician	1. Decedent's Name (First, Middle, Last) William E. Steridan	2. Date of Death Month Day Year March 19 2004 2 21 AM
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loc  Upper Chrapes Har Medical Gosfer Bel So	eation of Death  4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthday) If Under 1 Year III Months Days Hi	Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 11, 1925 New York
with the Maryland a or 28e-1 show the restified at	Usual Residence of Decedent	10d. Inside City Limits  1 ☐ Yes 2 ☐ No  X  10g. Citizen of What Country?
er death flems 23 her num	3 Widowed 4 Divorced  1 X Yes 2 No Korean If Yes, Give Year or Dates: Conflict  1 Yes 2 No Sp	nic Origin? (Specify Yes or No- lexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: white
n 72 n 72 n edic	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  5+  Director of pay  18.	g most of working
104 0221  10re, Maryland 212  109es 1 and 2 should be filed within to fleath and Mental Hygiene.  11 item 27 is marked other than or other traumatic evant, the Mental Hygiene.  To Be Comp	Barbara Sheridan/wife 712 Myer Creek I	Catherine O'Keefe  Number or Aural Acute Number, City or Town, State, Zip Code)  Road, Lancaster, Va. 22503  Date 20c Location - City or Town State
Baltimore, Miser Baltimore, Miser Baltimore, Miser Beatment of Heath a Department of Heath any injury or other tra	1 Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  21. Signature of Funacal Service Licensee  22. Name and Address of Schimunek	3/22/04 Baltimore, Md. Facility Funeral Home of Bel Air, Inc.
Physician /Medical Examiner  Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, surshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Universitying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ch as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death
ox 687 certificate nding phys use as the	d	23d. Date of delivery Month Day Year
ords, requires the requirement of th	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in a cutter my o cord call in farch ow	1 Yes 2 No 3 Probably 4 Unknown
Vital Record Vital Record Stein: The law requi	25. Was case referred to medical examiner?	24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1
on of one of on	1 Yes 2 TNO  Hospital: 1 patient 2 EP/Outpatient 3 DOA Other: 4   27. Mann Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	
Division  Division  Division  Division  To the Hospital or Attant  Within 24 hours after death  To the Funeral Director:  completely filled in by the  Medical Certificat	4 Homicide determined 259. Place of injury - At nome, farm, street, factory, office building, etc. (Specify)  299. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, day	28f. Location (Street and Number or Rural Route Number, City or Town, State)  Ite and place, and due to the cause(s) and manner as stated.
To the Hosp with 24 hos To the Funa Completely fill	29b. Signature and title of certifier  29c. License num  H 00 55	, death occurred at the time, date and place, and due to the cause(s)
State Registrar	31. Date filed (Month, Day, Year) MAR 2 3 2004  32. Registrar's Signature  January Ly  Aparks	

ORIGINAL

			For State Registrar	State of Maryland	d / Department of Health and M Certificate of Death	lental Hygien	- 711111	09129
	Physici /Medic	al 🤈	1. Decedent's Name (First, Middle, Last)  FRANK Selo 4a. Facility Name (If not institution, give str	OROWSKI	4b. City, Town, or Location of Death	2. Date of Death Month	Day Year Ac. County of Death	3. Time of Death 9:30 A M
	Examin Funeral Director	er	701 NORTH FOUN 5. Social Security Number 6. Sex 218-05-0502	Hain Gheli 7. Age (In yrs. Ia 8.3	Rd. Bel Air	8. Date of Birth (Month, Day, Yea	Harlor	d place (State or Foreign ntry)
	with the Maryland a or 28e-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  ADD ADDOR	ld Be	Town or Location			10d. Inside City Limits 1 ☐ Yes 2 No
0036	be filed within 72 hours after death with the Marylan at all typiene.  All typiene.  And other than "natural; or thems 23a or 28e-f show other than "natural; or thems 23a or 28e-f show ovent, the Madical Examiner must be nutified at	by Funeral Director	10e. Street and Number  70 NOTH FOU  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Utaun Gloun  2. Was Decedent Ever in U.S. Armed Forces?  1 XYes 2 □ No If Yes, Give Year or Dates:	10f. Zip Code  2/0/5  13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:		14. Race - Ameri Black, White	can Indian,
-C1717 D	filed within 72 hou Hygiene. other then "nature ent, the Medical E	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Metal luffs  18. Mother's Nam.	ing 16b. But	Kind of Business/Ir  Hilchen  en Sumame)	ndustry 1 Steel
rylan	should be nd Mental marked c	To Be	Adam Sehor 19a. Informant's Name/Relationship (Typ	OWSKI e, Print)	19b. Mailing Address (Street and Number or Run	Pil+RO al Route Number, City	WSKi y or Town, State, Zi	o Code)
re, Ma	ges 1 and 2 should tof Health and Mer if item 27 Is marke or other treumatic		Rose Marie Schor 20a. Method of Disposition	ce	ace of Disposition (Name of metery, crematory or other place)	Bel A Date 20 20c.	Location - City or T	JIO15 own, State
Baitimor	permit. Pages Department of i Importent: If it any injury or o once.		1 Burial 2 Scremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	EVAL	NSFUKOFO Charel - Zie 20 22. Name and Address of Facility EV	on For	eal Chape	I-Beldek
200	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	Do not enter the mode of dying, such as cardiac lefo Tic CAROLOVASCUL		EASE	Approximate Interval Between Onset and Death  Ten years
	/Medical Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque				
/60,	death certificate be executed e attending physicien and of for use as the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):			
9	leath certificate attending phys ifor use as the		d.  IF FEMALE:	c. If yes, outcome of pregnan	ncy		23d. Date of deliv	
O. Box	the death or y the atten ached for u	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of decent in the control of the	death 3 Ectopic pregnancy	<del></del>	Month	Day Year
rds, P	law requires that the de: as been signed by the a 2 should be detached fo	by	Part II. Other significant conditions cont	ributing to death but not resul	Iting in the underlying cause given in Part I.		o use contribute to	the cause of death?
Il Records,	The ate h page	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑	prior to co death?	opsy findings available impletion of cause of
Vital	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:	Othor	h (Check only one)	2 Flower (Co	<b>.</b>
ō	<u>a</u> = <u>a</u>	-	1 Yes 2 No 15  27 Manner of Death 1 No Natural 5 Pending 2 Accident investigation		## A DOA	me 5 x Residence 28d. Describe how in		(y)
Division	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rui ite)	al Route Number,
	e Hospitel or 24 hours afte e Funerel Dire letely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of my know er: On the basis of examinati and manner stated.	viedge, death occurred at the time, date and place, ion and/or investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier	1	29c. License number		Date signed (Month,	
	3	Į.	30. Name and address of person whom	mpleted cause of death (Item	23a) (Type, Print) THAVENUE BELAL	m/	4RCH 19	2004
	\		DR. Mack We	ld 2 NOR	THAVENUE BELAI	R MAR	1 CAND 0	21014
	Sta Regist		31. Date file (14) (h. 2ay Ye 21) 4	32 Registrar's Stanati	god.			

			1 - For State Registrar	State of Maryland / Dep <i>Ce</i>	artment of Hea		Hygiene Rea. No	2001.	Na	131
	*		Decedent's Name (First, Middle, Last)			2. Date of	of Death		3. Time of	Death
П	Physici		John Francis Su	llivan		Month March	19, <sup>Da</sup>	y Year 2004	9:45	АМ
	/Medic		4a. Facility Name (If not institution, give stre		4b. City, Town, or Loc			. County of Death	,,,,,	
			Ruxton of Pikesvil	1e	Pikesville	<u>م</u>		Baltim	ore	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	If Under 1 Year   If	Under 24 Hrs.   8 Date of	f Birth , Day, Year)	9. Birthp	lace (State o	r Foreign
Ь	Director		020-09-6432	<sup>1 2 F</sup> 84 Yrs.	Months Days		, 1919		chuset	its
	pud *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			1	0d. Inside Cit	ty Limits
	sho	ō							1 🗆 Yes	•
	28a-i	Director	Maryland Baltimor  10e. Street and Number	re Timo	11um 10f. Zip Code		10a Ci	tizen of What Cour	tn/2	
	with with	ă		1		2	- 7/5		tt y :	
	leath	Funeral	224 Burning Tree R		Was Decedent of Hispar	onic Origin? (Specify Yes o		JSA 14. Race - Americ	an Indian.	
	fter d	Fun	1 ☐ Never Married 20 Married	Armed Forces? 1 X Yes 2 □ No	If Yes, specify Cuban, M	lexican, Puerto Rican, etc	.)	Black, White,		
3	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No S	pecify:		Specify: Whi	te	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or items 23a or 28a-1 show event, the Medical Evantion must be notified at	Completed	15. Decedent's Educa	tion 16a. Dece	dent's Usual Occupation		16b. K	ind of Business/Ind	lustry	
215	hin 7 8. Med	pje	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done durin DO NOT use retired)	g most or working				
2	ad wit	Con	12	5+	Educator			Educatio	n	
2	be file	Be (	17. Father's Name (First, Middle, Last)		18.	Mother's Name (First, Mi	ddle, Maiden	Sumame)		
<u>a</u>	should be and Mental marked o	2	Corneilius Edwar	d Sullivan		Jennie	I	rancis		
a	and and ls m		19a. Informant's Name/Relationship (Type	, Print) 19b. Maili	ng Address (Street and I	Number or Rural Route N	umber, City o	or Town, State, Zip	Code)	
	of Health of Health litem 27		Mildred C. Sullivan			ee Road, Tim	onium,	MD 210	93	
ore	it of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Ren	20b. Place of Disponental from State	osition (Name of matory or other place)	3/22/04	20c. Lo	ocation - City or To	wn, Stete	
altimore,	Pages ment of ant: If its ury or o		*4 □ Donation 5 □ Other (Specify)		Valley Me. (		Ti	monium, N	iaryla:	nd
ā	permit. Pages Department of Important: If is any injury or o		21. Signature of Funeral Service License	2	2. Name and Address of	Facility eral Home of	Dular	nev Valle	v Inc.	
<u> </u>	207 2 9		Bryan W. Clary	cery	10 W. Pador	nia Road, Ti	monium	MD 21	093	
			23a. Pert1. Enter the disease, or complica shock, or heart failure. List only one	tions that coused the death. Do not en	, ,		-		Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	MYOCARDI	m NH	ARCTION	/	1 min	Onset and D	eath
	/Medical		resulting in death)	Due to (or as a consequence of):		, , , , ,		100117	11/83)	1-
M	Examiner		Sequentially list conditions, b.							
	ם יו	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):						
	acute and trans	me	that initiated events c							
Ö,	cate be executed physicien and the burial-transit		1000king in obality Labit	Due to (or as a consequence of):						
8760	cate b	dical	d					-		
9	entific ding p	Me	IF FEMALE:	16				-55 - OH - 1 - 1		
Вох	death certific e attending pl id for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		T	23d. Date of delive Month		'ear
0	0 0 0	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5 [ 9☐ Unknown	Other (specify)		_		,	
<u>a</u> .	The law requires that the de ate has been signed by the a bage 2 should be detached t	Ph	Part II. Other significant conditions contri	buting to death but not resulting in the u	nderbing cause given in	Part 23a [	Oid tobacco I	use contribute to th	a cauca of de	aath?
Š,	signe signe	l by	Tarrit of the organization of the	butting to doubt but not resulting at the o	noonying cause given in				ably 4 ∏U	
Ö	w require been sig should t	etec					•	7		
ec	elaw hast	Completed				a	Vas an lutopsy	24b. Were autor	sy findings a apletion of ca	ivailable luse of
Vital Records,		S				1 🗆 Y	erformed? es 2☐N/o	death? 1 ☐ Yes	2□ No	
VII:	Physician: Th this certiticate ral director, pag	Be	25. Was case referred to medical examiner?	enital:		Place of Death (Check of	nly one)			
5	Physic this cral dir	2	I Has STANO	ipital: 1 Inpatient 2 ER/Outpatie		Fursing Home 5□ F			)	
Division of	il or Attending P after death. I Director: After t d in by the funera	Certification:		28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?		ibe how injur	y occurred		
<u>s</u>	tend death tor: ,	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Diagonal Initiation Address from the	M 1 Yes			444	0	
$\leq$	or A	rtif	4 Homicide determined	<ol> <li>Place of Injury - At home, farm, str building, etc. (Specify)</li> </ol>	eet, factory, office	City or	Town, State	d Number or Rurai )	Houte Numb	) <i>01</i> ,
_	pital		20a Cartifica 15 Cartifying Physics	ing. To the best of my knowledge, does		1				
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: Alter this certifical completely lilled in by the funeral director.	edical	29a. Certifier 1 Cartifying Physic (Check only one) 2 Madical Examiner	<ul> <li>ian: To the best of my knowledge, deat</li> <li>r: On the basis of examination and/or in and manner stated.</li> </ul>	vestigation, in my opinior	n, death occurred at the ti	me, date and	and manner as sta place, and due to	the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title/of certifier	)	29c. License nur	mber	29d. Dat	e signed (Month, L	Dey, Year)	
	⊢≯⊢ŏ		b 4 ×	n	1 1,0.	110	1110	1	3-	21 1/
	nt1		30. Name and address of person who comp	pleted cause of death (Item 23h) (Time	Print)		1/1/1	uy k	100	7.
	10		50. Harrie and address of person who comp	A 14 A T A T	Ph 112 1-	as BA	D MA	1 2/20	¿-	
OR	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature	15	17, 10186	11	1 111	)	
	Registr	- 110	MAR 2 3 2004	from st Ag		1				

			1 - For State Registrar	State of Ma	ıryland / [	Department <i>Certificate</i>	of Healt of Dea	h and M <i>th</i>	ental Hyوا ا	giene Reg. No. 201	04 09131
	Physici /Medio		Decedent's Name (First, Middle, Le  Edware  Edwar	ed Brydon S	tubbs				2. Date of Dea Month MARCH	Day	3. Time of Death
	Examir Funeral		4a. Facility Name (If not institution, gi SAUT AGUES 5. Social Security Number 6.	ve street and number)  TEACTH CA  Sex 7. Age	RE (In yrs. last bir	BAL	Timol  Year If Un Days Hou	DE der 24 Hrs.	8. Date of Birth (Month, Day SEP 26	4c. County of	N/A  9. Birthplace (State or Foreign Country)
35	Director		212-07-9409   Usual Residence of Decedent   10a. State   10b. County		89 10c. City, Tow				SEP 26	, 1914	Maryland  10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "neturel", or items 23e or 28e-f show event, if a Medical Exert extractor for the Medical Exert extractor.	i Director	Maryland Balts 10e. Street and Number 210 S. Rolling			Cate	onsvill <sup>Code</sup> 21228			10g. Citizen of Wh	1 ☐ Yes 2 🕅 No
36	rs after death	by Funerai	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:		13. Was Decede If Yes, speci	ent of Hispanic rfy Cuban, Mex	Origin? (Spe ican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	- American Indian, , White, etc.
Maryland 21215-0036	within 72 hou ene. than "natural fe Medical E	Completed h	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Education rade completed)  College (1-4or 5-		Decedent's Usual (Give kind of work life. DO NOT use	k done during t e retired)	nost of worki	ng	16b. Kind of Busi	iness/Industry
land 2		To Be Co	17. Father's Name (First, Middle, Las Herbert A	5+ lvin Stubbs		Enginee	1		(First, Middle, Scarf I	Maiden Sumame,	Space
	and 2 shu lealth and m 27 is m		19a. Informant's Name/Relationship David Brydon Stul		6	. Mailing Address 509 Fred	erick F	Road (		ille, MD	
Baltimore,	t. Pa rtmen rtant:		1 ☐ Burial 2 ⚠ Cremation 3 [     4 ☐ Donation 5 ☐ Other (Spec	ify)	cemeter	ry, crematory or oth Cremator 22. Name and	y, Inc.	3/19	0/04	Balti	imore, MD
Ba	permi Depa Impo any ir		Dawn W And Co.  23a. Part1. Enter the disease, or cor shock, or heart failure. List only	pplications that caused yone cause on each lin	the death. Do i	299 Fr	ion Soc ederick	ciety c Road	Baltin	land, Inc nore, MD rest,	21228 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	ATERAC I consequence	- PNSU on: IPHOCYTI	MONIF		^		Onset and Death 4 DAYS
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence	of):	c hz	UKEN	1117		1 TOTAL
P.O. Box 68	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pre 5 □ Other (spe				23d. Date of Month	,
	The law requires that the site has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions CORONARY ART			the underlying ca				_	ute to the cause of death?  Probably 4 Unknown
tal Rec		e Compieted	25. Was case referred to medical				26 P	ace of Death	24a. Was a autops perform 1 Yes	sy pric med? dea 200 No 1 E	ore autopsy findings available or to completion of cause of ath?
Division of Vital Records,	ding Phys	tion: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigator	Hospital: 1 Inpatier 28a. Date of Injun (Month, Day	/ 28b. 1		Other: 4 Co. Injury at Work?	2		ence 6 Other	· · · · · · · · · · · · · · · · · · ·
Divis	To the Hospital or Attenowithin 24 hours after death To the Funeral Director:	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	building, etc.	. (Specify)	rm, street, factory,			City or Town	n, State)	or Rural Route Number,
	o the Hospital or A thin 24 hours after the Funeral Dire impletely filled in b	Medicai	29a. Certifier (Check only one)  2   Medical Example of certifier	hysician: To the best o miner: On the basis of and manner stat	examination an	d/or investigation,	t the time, date in my opinion, License numb	death occurre	ed at the time, d	ate and place, and	ner as stated. d due to the cause(s)  (Month, Day, Year)
	1		Ant C	completed cause of de	ath (Item 23a) (	F	1670		}		8, 2004
	Sta	ite	ERINGE, AYODE  31. Date filed (Month, Day, Year)	LE M.S.	_	South CA	Ton	Avenue	E, BAL	TIMORE	MD 81229.
	Registr	ar	MAD 9 9 70	nd Barana	A Second	mark!					

DHMH 17 Rev 1/2001

SWEEN

VIICHABEL

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** John Edwards Stafford 2004 March 18, 2:36 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 29,1935 Birthplace (State or Foreign Country) **Funeral** Days 1**X**M 2□ F 218-32-8011 Director Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28e-fahow item 27 is marked other than "natural", or Items 23a or 28e-f ahov other treumatic event. The Mudical Exercities research Maryland Baltimore White Hall 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2434 Garrett Rd. 21161 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 X Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. s marked other than Elementary/Secondary (0-12) manager real estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be fund Mental & Edward Edwards Stafford Dorothy Causey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other treum John E. Stafford Jr./son 2434 Garrett Rd. White Hall, MD 21161 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery Mar. 20, 2004 Pikesville, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licenses 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, glock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Streptococcal Pnysician populum mis resulting in death) /Medical Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be executed Due to (or as a consequence of): 68760 physician Physician/Medical the t IF FEMALE detached for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Pulmonay diseas certificate has autopsy performed? polio syndromi erred to medical y Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11 Chatte D20907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n Chatham 6569 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Richard P. Stafford 04-1 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep	artment of Health and	d Mental Hygien	e2001 0010
	1 - State Amend & Unper Registrar AMEND ITEM #5	State of Maryland / Dep. nd Item #1,23a,27,28 PER FH C829,3/29/04, JH	nificate of Dealth	3/25/04 tas Reg. N	3. Time of Death
Physician		s) <b>Richard Pául' Staff</b> STAFFORD SR	ora	Month D	ay Yeer
/Medical			4b. City, Town, or Location of D	March 15,	2004 10:00 A
Examiner	6401 Crestwood F	_	Baltimore		Baltimore
Funeral	5. Social Security Number 6.	Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 I	Hrs. 8. Date of Birth (Month, Day, Yea	9 Birtholace (State or Forei
Director	218-03-0918 218-02-0918 Usual Residence of Decedent	XX M 2□ F 35 Yrs.	Months Days Hours in	April 25,1	968 Maryland
than 'natural', or items 23e or 28e-f show then 'natural', or items 23e or 28e-f show the Madical Examiner ment by modified at ompleted by Funeral Director	10a. State 10b. County	10c. City, Town or L			10d. Inside City Limi
Ba-1 s	Maryland Baltim	ore Baltimor			1 ☐ Yes ��\
or items 23a or 28a-1s ribsermant by notifie. Funeral Directo	10e. Street and Number 720 Overbrook Ro	ad	10f. Zip Code 21212		Citizen of What Country?
ems 2	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po	(Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
Example Example by Fu	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 為如 No If Yes, Give Year or Dates:	1 ☐ Yes XX No Specify:		Specify: White
ygiene. ter than "natura t, the Medical is Completed	15. Decedent's E (Specify only highest gi	ade completed) (Give	edent's Usual Occupation e kind of work done during most of	working 16b.	Kind of Business/Industry
han mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		Domadalina
Hygiene wher the ent, the			d Coordinator	Name (First, Middle, Maide	Remodeling
Mental H larked oth latic svsr	D Latel Miller 1 C			n Isabel Sti	
and is m	19a. Informant's Name/Relationship Joy L Stafford	(Type, Print) 19b. Mail	ing Address (Street and Number of Overbrook Road B	Rural Route Number, City	or Town, State, Zip Code)
Department of Health Importent: If item 27 any injury or other tr once.	20a. Method of Disposition	20b. Place of Disp	osition (Name of		Location - City or Town, State
or of	1 ☐ Burial XXX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	matory or other place)		timore, Maryland
artme orten injury	21/Signature of Funeral Service Lice				ld Funeral Home Inc.
Depa Impo any ir once.	Donnin Nech	In (Kenakio)			re, Maryland 21212
ysician and important transit aburial-transit	Sequentially list conditions, I any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dua to (or as a consequence of):  C.  Due to (or as a consequence of):			
ysicia se bus	3	d			
e attendir d for use Ician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
		contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
nis certificate has been signed by th I director, page 2 should be detache To Be Completed by Phys				24a. Was an autopsy performed?	24b. Were autopsy findings availa prior to completion of cause death?
r death.  ctor After this certificate by the funeral director, particular to Be Cc			26 Place of	1 Yes 2 ☐ N Death (Check only one)	lo 1XYes 2□No
his certifi il director To Be	examiner?  • ¥XX es 2 □ No	Hospital:	Othor	g Home 5 Residence	% Other (Specify) At scer
	27. Manner of Death	28a. Date of Injury 28b. Time		28d. Describe how in	
ath. e funer e funer e funer	1 Natural 5 Pending 2 Accident investigati	Found 3/15/04 Found 9:46	Unknown		
rs after death.  al Director After to the in by the funeral Certification:	3 ☐ Suicide 6 € Could not determine	be 300 Blace of louist. At home form of	treet, factory, office	28f. Location (Street City or Town, Sta	and Number of Rural Route Number te <b>b401 Crestwood</b> Rd
al Dir ed in Cert		Found: private d	welling	Baltimore	
within 24 hours after deall To the Funeral Director completely filled in by the Medical Certificat		hysician: To the best of my knowledge, deaminer: On the basis of examination and/or in and manner stated		ace, and due to the cause	s) and manner as stated.
within 24 hours after To the Funeral Director to the Funeral Director to the Funeral Director To the Funeral Cert	29b. Signature and title of certifier	1 011	29c. License number	29d. C	Date signed (Month, Day, Year)
		AUX IVI	O.C.M.E.	Ma	rch 16, 2004
		complete cause of death (Item 23a) (Type		310	3
(0)	S.K. H	DOM	111 Penn Street	, Baltimore,	Maryland 21201
State	31. Date filed (Month, Day, Year)  MAR 2, 3, 21	32. Registrar's Signature			

		4	State	tate of Maryland /	•	rtment of He			2001.	09135
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	incate of L	Jeani	2. Date of Death	3	3. Time of Death
	Physicia	ın		ARTZ.				Month	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or		MARCH	4c. County of De	
	LXamin	-1	LEVINDALE HEBREW HO			BALTIMO	RE			N/A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9. Bi	rthplace (State or Foreign
	Director		210-02-2709	<sup>2</sup> X <sup>F</sup> 86	Yrs.	Worting Days	Tiodis Iviii.	FEB. 18,	918	MD
	pur *	}	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Loc	ation	-			10d. Inside City Limits
	daryli f sho	5	MD N/A		BALTI	MODE				1 Ves 2 No
	28e	rect	10e. Street and Number		ALII	10f. Zip Code		10	g. Citizen of What C	Country?
	3a or	0	2434 W. BELVEDERE A	VENUE			21215			U.S.A.
	death	Funeral Director		Was Decedent Ever in U.S. Armed Forces?	13. V	/as Decedent of His Yes, specify Cubar		ecify Yes or No-	14. Race - Am Black, Wh	erican Indian,
2	or its	/Fu	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 🏋 No If Yes, Give	i	☐ Yes 2(又 No	Specify:	riidari, etc.)	Specify:	WHITE
	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	l			1		
2	"nat	Completed	15. Decedent's Educat (Specify only highest grade ∝		(Give I	ent's Usual Occupa kind of work done d O NOT use retired;	uring most of work	ing 1	6b. Kind of Busines	s/Industry
7	withi iene. than	duo	Elementary/Secondary (0-12)	College (1-4or 5+)	ONE	,			NONE	
2	be flied within 72 hours after death with the Maryland Hygiene. A Hygiene. d other than "natural", or itams 23a or 28e-f show event, if e Mudical Exprimer nast be notified at	a)	17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle, N		
0	ould be filed with Mental Hygiene arked other tha atic event, Ire	To B	MEYER	5	SCHWA	RTZ	GOLD1	Ε		COHEN
<u>a</u>	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Type,						City or Town, State,	
<u>×</u>	1 and 2 Health tem 27	1							ILLE, MD 2	
2	Pages 1 and 2 should be filed within 72 hours after death with the Marylan bent of Heath and Mental Hygiene. I be not it feath and Mental Hygiene. In: If time 27 is marked other than "natural; or itams 23a or 28e-1 show in; or other treumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1	oval from State cernet	ery, crem	ition (Name of atory or other place	9)		20c. Location - City o	
altillor	t. Pa rtmen rtant: rjury		'4 Donation 5 Other (Specify)	WORKI		CIRCLE CE		2/2004	DUNDALK,	
D	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other 2006e.		21. Signature of Funeral Sovice Licensee						ON & BROS. [KESVILLE,	, INC. , MD 21208
Г	8		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one	ions that caused the death. Do	not ente	r the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ENO STAGE						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequenc						
	LAdimino	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	0.04):					
	ted nsit	nine	cause. Enter Underlying	Due to (or as a consequenc	6 OI).					
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	tificate ng physi as the I	Φ.		·						
۵ 2	es that the death certific igned by the attending p be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3 🗆	Ectopic pregnancy			23d. Date of d	
	the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 🗆	Other (specify)			MOIIII	Day Year
7.	hat the ed by th detache		Part II. Other significant conditions contri	outing to death but not resulting	in the un	deriving cause give	en in Part I	23e. Did tob	acco use contribute	to the cause of death?
as,	requires that sen signed b nould be deta	d by			,					Probably 4 Dunknown
ecoras		lete						24a. Was ar	24h Wara	autopsy findings available
Ĕ	sician: The law certificate has b irector, page 2 sl	Completed						autopsy	prior to death?	completion of cause of
VII	an: T tificat tor, pa	O	25. Was case referred to medical				26. Place of Deat			s 20No
		To B	examiner?	pital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatien'	3 DOA Othe	or: 4 Nursing Ho	me 5 Reside	nce 6 Other (Sp	ecify)
I0 I	ttending Phy death. stor: After this the funeral o		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b	. Time of Injury	28c. Injury Work	at	28d. Describe ho		
sion	tendi leath. Ior: A the fu	cati	2 Accident investigation				res 2□No			
2	or Att after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (Str City or Town	eet and Number or I State)	Rural Route Number,
_	spital	al Ce	29a. Certifier 1 Certifying Physic	ian: To the best of my knowled	lge, death	occurred at the tim	e, date and place,	and due to the ca	use(s) and manner a	as stated.
	n 24 h	edic	(Check only 2 Medical Examine one)	On the basis of examination and manner stated.	and/or inv	estigation, in my op	pinion, death occur	red at the time, da	ite and place, and di	ue to the cause(s)
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	M	29b. Signature and title of certifier	,		29c. License			d. Date signed (Mor	
)	1		Nonna m.	areuley m	.Δ.	054	139.	1	MARCH	19th 2004.
	S		30. Name and address of person who comp							
			2434 W. Belved 31. Date filed (Month. Dav. Year)				ore. Mi	ing land	71215 H	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 3 2004	3. Registrar's Signature	dos	SE .				

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			1 State AMEN			-	•	artment of I			ntal Hyg	jiene		
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	/Medic Examin	al	A . A	If not institution, giv	e street and number	r)		4b. City, Town,	or Location	on of Death		4c. County		2 F M
			North	HWEST	T Hosp			If Under 1 Year		der 24 Hrs.   8		131	427	IMORE
ě	Funeral Director		5. Social Security N 216-09-06	53	XM 2 F		last birthday)  88 Yrs.	Months Days		's Min.	Date of Birth (Month, Day 6/7/19	15 Year)	Cou	place (State or Foreign intry) YLAND
	yland		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	he Mar 28a-f sh cuffed	Director	MD	BALTIM	IORE	BA	LTIMOR					10g. Citizen of V	Mhat Cau	→ WYes 2√No
	3a or 3	I Dir	10e. Street and Nur 4420 EVA	MAY RD. /	APT.2-A			10f. Zip Code 2121	15			U.S.A.	VIIAL COU	mtr <b>y</b> :
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	72 hour			15. Decedent's E	ducation			dent's Usual Occu		nost of working		16b. Kind of Bu	ısiness/Ir	ndustry
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2	Departiment of the particular		•	Mare)				8900 REIS	STERS	STOWN R	D. PIK	ESVILLE	, MD	INC. 21208
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w.	Examiner up pu	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	injury	b. Due to (or a	is a consec	quence of):							
00700	tificate be executed ig physicien and as the burial-transit	70	resulting in death)	Last	Due to (or a	is a consec	quence of):							
.O. DO.	To the Hospital or Attending Physicien: The law requires that the death certificate to within 24 hours after death.  For the Funeral Director: Atter this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the beautiety.	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 ( 9 Unknown	months?	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	al déath 3	□Ectopic pregnand □ Other (specify) _	;y			23d. Dat		ery Day Year
r (epi	w requires that s been signed t should be deta	by	Part II. Other signif	ficant conditions of	contributing to death	but not res	sulting in the u	inderlying cause gi	ven in Pa	irt I.		bacco use contr es 2 □ No	ribute to t	he cause of death?
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5	ding Phys I. Alter this funeral di	-	27. Manner of Deat	<u> </u>	28a. Date of In (Month, E	jury	28b. Time o	f 28c. Inju				ow injury occurr		)))
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נ	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Ce	29a. Certifier (Check only one)	Certifying Ph	nysicien: To the bes miner: On the basis and manner	of examina	owledge, deat ation and/or in	h occurred at the t	ime, date	and place, and death occurred	d due to the c at the time, c	ause(s) and ma late and place, a	nner as s	stated. o the cause(s)
	To the Within To the	Me	29b. Signature and	title of certifier	New	~ l	M	29c. Licen				19d. Date signed		Day, Year) 7, 2004
	b		30. Name and addi	ress of person who	completed cause of	death (Iter	n 23a) (Type,	Print)	M	921	133	>		
	Sta Registr		31. Date filed (Mon	MAR 2 3 2	2004 32. Fegis	strar's Signa	ature de	Book						
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		-	For State		State of M	aryland	d / De <i>C</i>	partment of ertificate o	Health of Death	and Mer	ntal Hyg	jiene, log. No.	2004	0913	37
	Physicia	an	Registrar  1. Decedent's Name (F  Eleanor								Date of Dea Month	ith Day	Year	3. Time of Dea	
	/Medic	al -	4a. Facility Name (If no			1)		4b. City, Jown	n, or Location		9		County of Death	X - P	ò
			fren 12/) 5. Social Security Number	1	1ale	16 S  e (In yrs. I	f   + 62	If Under 1 Ye		r 24 Hrs. 8.	Date of Birth		9. Bjrthr	lace (Stete or Fo	preign
	Funeral Director		419-24-083 Usual Residence of De	1 1	M 21₹F	80	Yrs	Months Da	ys Hours	Min. Ap	Date of Birth (Month, Day	4,192	23 George	place (Stete or Fo ntry). GLA	
	nyland how		10a. State 10	0b. County			y, Town or						1	0d. Inside City Li 1  Yes 2 □	
	the Maryland r 28a-f ehow	ecto	Maryland  10e. Street and Number	N/A		Ва	ltim	10f. Zip Coo	e			10g. Citiz	en of What Cour		
<u>_</u>	東の四	ai Dir	4015 Park		ive			21206				u.s.			
0-17 © 136	after or Ite	by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4	2 Married	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give X Year or Dates:	,	.S. 1	3. Was Decedent If Yes, specify ( 1 ☐ Yes 2 🖔	Cuban, Mexica	an, Puerto Rica	Yes or No- an, etc.)		4. Race - Americ Black, White, Specify: White	etc.	
215-0036	"natural",	leted	15 (Specify	only highest grad	e completed)		16a. De (G	icedent's Usual Ocive kind of work doe. DO NOT use re	cupation one during mo tired)	st of working		16b. Kin	d of Business/In	dustry	
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and	2 should be filed within and Mental Hygiene. Ie marked other then aumatic event, I'm M	Be	17. Father's Name (Fin Robert H.							ner's Name (Fi nie Eli					
₹ 50 N Maryland	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Ie marke any injury or other traumatic 0000.	은	19a. Informant's Name					ailing Address (Str						Code)	
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Tho Paltimore,	permit. Pages Department of I Importent: If Its any injury or o once.		`4 □Donation 5 [	Other (Specify)		Ba	iyvie	W Cremate	ory :	3/19/2	004	Bal	timore,	Marylan 10 Inc	.d
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A	and I-transit	Examiner	Gaqueritian, list condi- if any, leading to immediate. Enter Underlyi Cause (Disease or inju- that initiated events	ing ury	c										
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	the Hos in 24 h the Fur npletely	Medical	(Check only 2 one)	☐ Medicel Exem	niner: On the basis and manner:	of examina	ation and/	or investigation, in	my opinion, de cense numbe	eath occurred	at the time,	date and	place, and due to signed (Month)	o the cause(s)	
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_	4		30. Name and addres	ss of person who d		death (Ite		ype, Print) Sahare	QC VI	e Rm	Him	010	MD.	1237	1
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 1 - State AMEND ITEM #6 PER FH G829 3/25/04 JHCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** March 22, 2004 Nancy Lee 6:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 104 Glenmont Avenue Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) OCT 27, 19 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) <del>12 \*\*</del> XX F Months Days Hours Min 216-34-1037 66 1937 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28a-f show traumatic event, if e Medical Examiner must be notified at 1 ☐ Yes 2 XNo Maryland Anne Arundel Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Glenmont Avenue 21061 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Circuit Board Worker Electronics 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental Hytent: If item 27 is marked oth jury or other traumatic even Be Jerry Holler Kathleen Clark ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Matthai/Daughter 3013 Ritchie Avenue Sparrows Point, MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or 3-22-04 Metro Crematory Inc. Baltimore, MD Homa Licease Cremation Society of MD 299 Frederick Road Bal Inc. Thomas Gregor Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final Physician The on disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Esquentially list on differentially leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ပ 1 ☐ Yes 2 ☑ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier YOP March 22, 2004 AGADI 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) 305 Hos JVP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 3 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Leroy Veney 11:40A <sup>™</sup> March 17, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1∏M 2□F 214-90-9985 Director Mar. 13, 1942 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show r than "natural", or Items 23a or 28e-f show the Medical Experience outsides at 1 ☐ Yes 2 ☑ No Maryland Baltimore Directo Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7010 Upper Mills Circle 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2√√No Specify: Specify: Black δ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Custodian Special Program
17. Father's Name (First, Middle, Last) eMerge permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic event 9008. 18. Mother's Name (First, Middle, Maiden Surname) Leroy Veney, Sr. Elaine Wesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Wamsley (Friend) 9180 Rumsey Road Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/22/04 Dorsey, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MYDCARDIAL Immediate Cause (Final disease or condition resulting in death) INFARCTION Onset and Death Physician /Medical Due to (or as a consequence of): ARTERY DISEASE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine HYPOVOLEMIA attending physician and for use as the burial-transit Due to (or as a consequence of): TESTINAL BLEEDING Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 METASTATIC COLON CANCER 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown ANEMIA HEMORRHAGIC 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan has 1□ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending after death.

Director: After in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a To the Funerel C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29c. License number 38363 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCESCO GRASSO MD 6569 No CHARLES ST 32 Registrar's Signature 31. Date filed (Month, Day, Year) MAR 2 3 2004 State Registrar

Registrar

State

32. Registrer's Signature

111 Penn Street, Baltimore, Maryland 21201

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

m.D

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31. Dete filed (Month, Day, Year)

MAR 2 3 2004

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 201014 MARCH William Henry 06:30 White /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director 220-36-8175 61 July 6,1942 MD. Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ehow. item 27 is marked other than "naturel", or Items 23a or 28a-f ehov other traumatic event, the Madical Examinar must be restitived at 1 ☐ Yes 2 ☐ No Md. Baltimore Director Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ould be filed within 72 hours after death with t Mental Hygiene. arked other than "naturel", or Items 23a or 2 2904 Kings Ridge Road Apt B 21234 IISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Animal Control Baltimore County 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked 1 any jury or other traumatic even 2008. is marked William White II Norma Schaller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia White wife 2904 Kings Ridge Road, Parkville, MD. 21234, Apt B 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State March 25, 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 ☐Donation 5 ☐ Other (Specify) St. Stanislaus Ceme. Baltimore, Md. 2004 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21222 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Comot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE Physician /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-transit The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Id be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ed bluods PLEURAL EFFUSIONS 2 No 3 Probably 4 Unknown peen RENAL FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 2 No 1 Yes or Attending Physiclen: 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient 2 [
28a. Date of Injury (Month, Day Year) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification; To 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After t Natural 2 Accident 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Mon h, Day, Year) D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YHTOMIT LOW, 7601 OSLER TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Reginar's Signature State 3 2004 Registrar

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	17		30. Name and address of person wh		MD.	23a) (Type, F	5. 6K	EEN	H ST	. B	266 M ALTIMO	RE	MD	242	70)
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State of Maryland / Department of Health and Mental Hygiene 2004 09143 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Hazel A. Watson Month MARCH 2004 05:00 AM /Medical 4a. Facility.Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F 408-36-3087 Tenn. Director 76 Oct.9,1927 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location of Health and Menial Hygiene. item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, "its Medical Examination out the notified at 10d. Inside City Limits MD Baltimore 1 ☐ Yes Z☐No Director Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 South Taylor Ave. 21221 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: SpecifyWhit Be Completed by 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dentist Dental Assistant 8th permit. Pages 1 and 2 should be flik Department of Health and Mental Hy important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George McKinney Kate Hubbard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore Kolodziejski 1007 Cherlyn Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 1 Removal from State HappyValleyCemetery 3/26/04 Elizabethan Tenn. \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 lu 23a. Part1. Enter the disease, or compositions that caused the death. It not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List will ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRO-VASCULAR ACCIDENT Physician DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner -transit The law requires that the death certificate be executed and physician a the burial-Due to (or as a consequence of) P.O. Box 68760, Se IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ło Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe cate has been sig page 2 should b 2 No 1 Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 Yes 20 1 Tes Hospital or Attending Physician: Be funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Xinpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 22, 2005 D17695 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH 7601 HELOU M. D. OSLER DRIVE TOWSON, MARYLAND 21204 32. Registrar Signatur State Registrar

		1 - For State Ragistrar	State	e of Marylai		artment o				giene Reg. No.	004	09144
Dhyo	aia n	Decedent's Name (First, Mid	dle, Last)						2. Date of De	Day	Year	3. Time of Death
Physi /Med		Florence			Wachte	r			March	19, 2	004	2:00 P M
Exam	iner	4a. Fecility Name (If not institut						tion of Death		4c. Co	unty of Deeth	
		Millenium He			to a to be designed as			City	0.0		Howard	
Funera Directo		5. Social Security Number 213-74-3092	6. Sex 1 ☐ M 27(2)		. last birthday) Yrs.		ays Ho		8. Date of Bir (Month, Da NOV	$30^{\text{Year}}$ , 19	9. Birthp Coun 03 Per	lace (State or Foreign htry) nnsylvania
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036 burs after death with the Maryla rel', or Iteme 23a or 28a-1 ehor Examiner roust be notified at	Funeral Director	1243 Locust A	ve.				21227				U. S. A	•
deat	ner	11. Marital Status	12. Was	Decedent Ever in U	J.S. 13.	Was Deceden	t of Hispani	c Origin? (Spe	ecify Yes or No Rican, etc.)	p- 14.	Race - Americ Black, White,	
36 safter	by Fu	1 Never Married 2 M	rried 1 🗆 Y	es 2 XNo s, Give	}	1 ☐ Yes 2 页		ecity:	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	ecify: Whi	
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yla ould I	P	Robert H. Mit					An	na Mar	ie Engl	ert		
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Te, N 1 and Heatth tem 27	-	20a. Method of Disposition		20b.	Place of Dispo	sition (Name	of		ate		ion - City or To	wn, State
Baltimore, Maryland 21215-0 sermit. Pages 1 and 2 should be filed within 72 ho Department of Health and Menta Hygiene. Important: If them 27 is marked other then "naturing injury or other treumatic event, the Medical		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other		rom State	rraine	natory or othe Park C		rly 03.	-23-04		lawn, M	
alti mit. partm porta	ġ	21. Signature of Funeral Service							me, Inc		rawn, m	Б
<b>0</b> 88 E 5		Tretuo	El ?	en		1328 Su	Lphur	Sprin	g Rd.	Arbuti	us, MD.	21227
Physicial /Medica Examine Distriction and Pontial-Itansit	ical Examiner	shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)  Security list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b		queride of):	atio	ia	pnei	Jm o	niti	S	Interval Between Onset and Death
Vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certifica clash.  Totalh.  Sector: After this certificate has been signed by the attending phey the funeral director, page 2 should be detached for use as the present of the control of t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 70 9 Unknown	1 DL 4 DP	s, outcome of pregrive birth 2 Fet Pregnant at time of Inknown	el death 3	∃Ectopic pregr ] Other (s <i>pecit</i>				23d	. Date of delive Month	ry Day Year
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Division  To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Coul	mined 200. F	Place of Injury - At houlding, etc. (Spec	nome, farm, sti	eet, factory, of	ffice		28f. Location ( City or To		umber or Rurai	l Route Number,
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		30. Name and address of person	n who completed	cause of death (Ite	m 23a) (Type,	Print)		, ,				41
		RODOLFOF	ES NA		40 4	05 Fre	edon	arro	ste	162	Caller	vsnlle
Regis	tate strar	31. Date filed (Month, Day, Yea		2001	here	1	1					2100

		•	For Unpend	Item #2	State 1 23a-b, pt. 1	f Mary 1,27 p	land er me	/ Depa Seri	ertmen Hificati	t of H	ealth a	and M	lental Hy	giene	200	14	09145
			1. Decedent's Name (Fire										2. Date of D	eath		eer .	3. Time of Death
	Physicia		Clayton		Edward	We	1ch						MARCH	18,	2004	001	4:55 P™
	/Medic Examin		4a. Fecility Name (If not i	institution, g	rive street and nu	mber)			4b. City,	Town, or	Location	of Death		4c.	County of	Deeth	
		•	NORTH ARUN	NDEL H	OSPITAL					SLEN	BURN	ΙE		A	NNE A	ARUN	DEL CO
	Funeral		5. Social Security Number	er 6.	Sex	7. Age (ir	n yrs. lasi	t birthday)	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of 8. (Month., D	rth	9	9. Birthp	lece (State or Foreign
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a	permit. Pages 1 and 2 should Department of Health and Men important: If Item 27 is marke eny injury or other treumatic once.		21. Signature of Funera	Service Lic	censee	340.1	061	2:	2. Name ar	nd Addres	ss of Facili	Si	ngletor	Fun	eral	Hom	e
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20			23a. Part 1. Enter the di shock, or heart fail	sease, or co	omplications that	caused the	e death.	Do not en	ter the mod	le of dyin	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Between
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Вох	that the death certifical ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pre	gnant	23c. If yes, or	utcome of p			⊒Ectopic p	roonano:	,				23d. Date		
m	death e atte d for	<u>C</u>	in the past 12 mon		4∐Preg	mant at tim			Other (s						Mont	h	Day Year
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	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	y P	Part II, Dther significan	t condition	s contributing to	death but n	not resulti	ing in the u	underlying (	ause giv	en in Part	1.	23e. Did	tobacco	use contrib	ute to th	ne cause of death?
rds	quire n sig	D D	Seizure disord	der					<del></del>				1 🗆	Yes 2	<b>Z</b> Wo 3	☐ Prob	bably 4 Unknown
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on	Attending r death.	ţ	1 Natural 5 2 ☐ Accident	Pending investiga		nth, Day Y	(eer)	Injury	м		k? Yes 2.[	]No					
S	deat deat ctor: y the	fica	3 ☐ Suicide 6	Could no	t be One Blad	e of Injury	- At hom	e, farm, st	reet, factor	y, office						or Rura	al Route Number,
Division	after Dire	Certification:	4 Homicide	determin	buil	ding, etc. (	(Specify)						City or T	own, State	э)		
_	To the Hospitel or Attending Physicith 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.		29a. Certifier 1□	] Certifying	Physician: To the	ne best of r	my knowl	edge, dea	th occurred	at the tir	ne, date a	nd place.	and due to th	e cause(s	) and man	ner as s	tated.
	24 h 24 h Fur	edical	(Check only 2X	Medical E	xaminer: On the	basis of ex	xaminatio	n and/or in	nvestigation	n, in my o	pinion, de	ath occur	red at the time	, date an	d place, ar	d due to	the cause(s)
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			For State	State of	Maryland	•	artment of H			giene	nnı.	0011.0
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Mg.	Physici	an		VRIGH	~~~				MARCH	21 2	Year OO4	10:01 PM
	/Medic	9	4a. Facility Name (If not institution, g				4b. City, Town, or	Location of Death	MARCH		ty of Death	
	Examir	ier	HARBOR HOSPI				BALTI	MORE			n/a	
	Funeral	-		Sex 7	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	Vear)		lace (State or Foreign
0	Director		218-07-3904	1 💢 M 2 🗆 F	90	Yrs.	Months Days	Hours Min.	Sept.09			vland
	P .		Usual Residence of Decedent		10. 0:1	T						0d. Inside City Limits
	arylar show	_	10a. State 10b. County	,		Town or Lo						1 ☐ Yes 2 ☐ No
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	with the		10e. Street and Number 1233 William St	- woot			10f. Zip Code	0				шуг
	sath is 23	eral			dent Ever in U.S	13	Vas Decedent of Hi		ecify Yes or No-		.S.A.	an Indian.
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<u>la</u>	Menta Menta rrkad	10	Claude Merit	Wr	ight			Lillian	e Eng	le l		
Maryland	2 sho and h is ma		19a. Informant's Name/Relationship				g Address (Street a					Code)
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ore	or oth	li	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from S	State 20b. Pla	ace of Dispo metery, crei	sition (Name of natory or other place	θ)	Date	20c. Location	ı - City or To	own, State
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Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Lie	ensee Kevi	n E Eck	er 22	Name and Address McCul 237 E	ly-P01yn: L. Patapso	iak Fune co Ave.	eral Ho Baltin	me P.	A. Md. 21225
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87	physic the l	dical		d								
Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnan		75			23d. D	ate of delive	ery
	requires that the death een signed by the atter nould be detached for t	Icla	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregna	rth 2 ☐ Fetale ant at time of de		Ectopic pregnancy Other (specify)		-	N	Month	Day Year
P.0	t the by th tache	hys	9 Unknown	9□ Unkno	wn							
	w requires that s been signed b should be deta	by P	Part II. Other significant condition	s contributing to de	ath but not resul	Iting in the u	nderlying cause give	en in Part I.				ne cause of death?
g	en sig	ed							1 🗆 Y	es 2 Mo	3 Prob	ably 4 Unknown
000	S 0 2	plet							24a. Was a autop	an 24b	. Were auto	psy findings available impletion of cause of
Ä	Physician: The lay this certificate has al director, page 2	mo:							perfor	med2 2 No	death?	2 No
ita	ian: intifica	Bec	25. Was case referred to medical examiner?		_			26. Place of Deat	h (Check only o	ne)		
>	Physician: this certific	10	1 ☐ Yes 2 No	1		ER/Outpatier		4   Nursing no	ome 5 🗆 Resid	ence 6 🗆 O	ther (Specif	y)
0	ng Pl	ino	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date o (Monti	of Injury h, Day Year)	28b. Time o Inju <b>ry</b>	Work		28d. Describe h	ow injury occi	urred	
Sio	andi eath. or: A the fu	cati	2 Accident Investiga 3 Suicide 6 Could no					Yes 2□No				
Division of Vital Records,	or Att	Certification:	4 Homicide determin	ed 28e. Place buildin	of Injury - At hor ng, etc. <i>(Specify)</i>	me, farm, st )	eet, factory, office		28f. Location (S City or Tow		nber or Hura	I Route Number,
	urs al urs al urs al urs l D	Ce	176	N								
	To the Hospital or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier 1 ☑ Certifying (Check only 2 ☐ Medical Ex	enysician: 10 the ba and mann	asis of examinati	on and/or in	n occurred at the time vestigation, in my op-	ne, date and place, pinion, death occur	red at the time, o	ause(s) and r late and place	nanner as s e, and due to	the cause(s)
	o the ithin o o tha	Mec	29b. Signature and title of certifier	and main	ior statos.		29c. License	number		29d. Date sign	ed (Month,	Day, Year)
	⊢ ≯ ⊢ ŏ		& Salme C	wan	~ M.I	),	BPA	+#P16	768 1	MARCH	. 21	2004
	1		30. Name and address of person w	no completed cause	e of death (Item	23a) (Tvpe		10	. 00	11170	1-11	
	8		SALMA AKRAM					HANOV	ER ST.	BALT	MORE	, MD 212
	* * St	ate	31. Date filed (Month, Day, Year)		egistrar's Signat							
	Regist	rar	MAR 2	3 2004	Gener	as 1	& Spa	uls!				
					/		/ //					

DHMH 17 Rev 1/2001

ORIGINAL

			1100001	State of Maryla				d Montal Hy		Legible.	
			For State Registrar	State of Maryla		rtificate of		,	٠,	2004	0011.7
	o		Negistrar     Decedent's Name (First, Middle, Last)			ranoato or	Douth	2. Date of De			3. Time of Death
	Physicia /Medic		John Daytor	n Willard	4th.			March	Day	9, 200	4 5:15A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o	r Location of D	Death		County of Deat	
			Chesapeake Hosp			Linthi		Um la la la			rundel
	Funeral Director		5. Social Security Number 6. Sex 212-40-3362 1№	M 2□F 7. Age (In y)	rs. last birthday Yrs.	Months Days		Min. 8. Date of Bir (Month, Date of MAR 1.	th ay, Year) 103	9. Birt	hplace (State or Foreign buntry) SSACHUSETTS
			Usual Residence of Decedent					TEM	175	o mas	sacrusetts
	show	_	10a. State 10b. County		City, Town or L						10d. Inside City Limits
	he Ma	ecto	Maryland Anne Arund	del Ai	nnapoli				40- 000		1 Yes No
	with t	ā	1643 Orchard Beach	Road		10f. Zip Code 21402			USA	zen of What Co	iuntry?
	thin 72 hours after death with the Maryland e. an "naturel", or Itams 23e or 23e-1 show Medical Examinar must be motified at	Funeral Directo		2. Was Decedent Ever in	U.S. 13.		lispanic Origin	? (Specify Yes or No Puerto Rican, etc.)		14. Race - Ame	
٥	or its	Fu	1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 ☒ No  If Yes, Give  Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	ruento Hican, etc.)		Black, White Specify:	white
Š	hours tural',	Completed by	3 ☐ Widowed 4 ☐ Živorced		100 Door						
Ç	72 die	piete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	ident's Usual Occup is kind of work done DO NOT use retired	ation during most of d)	f working	160. Kir	nd of Business/	industry
51215-0036	e filed within al Hygiene. I other than vant, the we	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Boat	Builder			Mar	ina	
	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle	, Maiden	Sumame)	
<u>\Z</u>	should be nd Mental marked c	ဥ	John Dayton Willa		Lancatoria.			Alfieri			
Maryland	C/ cg -cg -cg		19a. Informant's Name/Relationship ( <i>Typ</i> John D. Willard 5			ing Address (Street 4 Orchard		r Rural Route Numb	-	is. MD	21401
as.	is 1 and of Health item 27 othar tr		20a. Method of Disposition	206		osition (Name of omatory or other place		Date		cation - City or	
Ë	Page nent o int: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ematory I		-20-04	Ba1	timore,	MD
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or otl		21. Signature of Funeral Service License	9	3	a Name and Addre	ssSociite t	ty of MD,			
n	202599		Thomas Gregor			299 Frede	rick ko	bad Balt	imor	e, MD	21228
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	eations that caused the de e cause on each line.	eath. Do not en	-		rdiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	lugar	aling	t ar	lu				
	Examiner		- 1	Due to for as cons	sequence 12	6.					
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence 7:	carr					
	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
760,	death certificate be executed e attending physician and of for use as the burial-transit	icai E	Tooling III doday, 2200	Due to (or as a cons	equence of):						
687	ficate phys s the		d.								
Box	leath certifical attending phy I for use as th	n/M	IF FEMALE: 23b. Was decedent pregnant	lc. If yes, outcome of pred		□e			2	3d. Date of deli	ivery
		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Dectopic pregnancy Other (specify)				Month	Day Year
о. О	nat the de d by the a	Phy	9 Unknown					00- Did			Ab
က်	taw requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions conf	ributing to death but not i	esuting in the i	inderiying cause giv	en in Part I.		Yes 2		the cause of death?
ecords,	v require been sig should t	ietec						24a. Was			topsy findings available
Re	0 0	Completed						- auto	psy ormed?	prior to death?	completion of cause of
Vita	iclan: Th certificate rector, pag	a)	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only		1 Ll Yes	2 No
ot <	S 5	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2		nt 3□ DOA Oth	er: 4 Nursir	ng Home 5 ☐ Resi	dence 6	Other (Spec	city)
	ing After une	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe	how injury	occurred	
Division	death death stor: / the	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	t home farm si		Yes 2 □ No		Street and	l Number or Ru	ıral Route Number,
2	i Sir fe	Certification:	4 ☐ Homicide determined	28e. Place of Injury · A building, etc. (Spe	ecify)				wn, State)		74. 7.03[0 / 44/7.007,
	To the Hospital within 24 hours a To the Funeral Completely filled		29a. Certifier 1 ☐ Certifying Physics (Check only 2 ☐ Medical Exemin	ician: To the best of my ler: On the basis of exam	(nowledge, dea	th occurred at the tir	me, date and p	place, and due to the	cause(s)	and manner as	stated.
	To the Hos within 24 h To tha Fur completely	Medicai	one)	and manner stated.				occurred at the time,			
	To To	-	29b. Signature and title of certifier	, ,	1	29c. Licens	5 33	26	29d. Date	signed (Month	i, Day, Year)
	T		30. Name and address of person who cor	poleted cause of death //	1111 tem 23a) (Tyron					11910	
	10		Curtos tarris	ind 888	2 Best	gate k	2 d Ste	- 211 A	nna	PULIS.	mo 21401
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature	and s			/		
	🏢 🚋 Registr	ar	MAR 2 3 2004	De Mess	No AS	-					

			1 - State of Maryland / Dep State of Maryland / Dep Ce	artment of Health and Natificate of Death		ne No.2004	09148
Г	Physicia		1. Decedent's Name (First, Middle, Last)  Cecilia F. Wong		2. Date of Death Month March 22	Day 2004 Year	3. Time of Death 7:00 A M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)  Natalie House	4b. City, Town, or Location of Death Silver Spring		4c. County of Death	
	Funeral Director		5. Social Security Number $081-34-3133$ 6. Sex $1\square$ M $2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ $		8. Date of Birth (Month, Day, Ye SEPT 2, 1		place (State or Foreign ntry)
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Montgomery Silver S				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23a or 28a at burnuti	ai Director	10e. Street and Number 410 Torrington Place	10f. Zip Code 20901	10g.	Citizen of What Cou	ntry?
7036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ther than "natural", or Items for Indilled at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes Z☐ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☐XNo Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White Specify:	
Maryland 21215-0036	filed within 72 h Hygiene. other than "natu ent, the Medical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of work DO NOT use retired) Lian	king	ederal Gov	,
yland	should be file nd Mental Hy marked othe umatic event	To Be (	17. Father's Name (First, Middle, Last) UNK •	UNK.	ne (First, Middle, Mai	,	
e, Mar	1 and 2 Health a sm 27 Is ther trai		Diana Baumohl/Daughter 1522	ing Address (Street and Number or Ru 4 Noonin Tree Co osition (Name of matory or other place)	urt Ches	ty or Town, State, Zi, sterfield, . Location - City or T	MO 63017
Baltimore,	Page nent ant: If ury o		'4 □Donation 5 □Other (Specify) Metro Cr	rematory Inc. 3-2	3-04	Baltimor	
E E	permit. Departing the property of the property		Thomas Gregor  23a. Part1. Enter the disease, or complications that caused the death. Do not en	2 Name and Address of Facility Cremation Society 299 Frederick Roa	d Baltin	nc. nore, Mu	21228
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cerebral Infar Due to (or as a consequence of):		or reappraising arrest,		Interval Between Onset and Death 24 Hours
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Thatte (Disease of Fig.)				
8/60,	ate be executed hysician and the burial-transit	dicai Examine	that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.		-		
O. Box 6	The law requires that the death certific: te has been signed by the attending pl tage 2 should be detached for use as in	ompleted by Physician/Mec		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
rds, P	quires that in signed b uld be deta	ed by Pł	Part II. Other significant conditions contributing to death but not resulting in the Alzheimer's Disease	underlying cause given in Part I.	23e. Did tobac	co use contribute to to 2 \( \bigcap \) No \( 3 \bigcap \) Pro	he cause of death? cably 4 □Unknown
Vital Hecords,	(0 17	O			24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
ō	ttending Physiclan: The death. ctor: After this certificate y the funeral director, pag	ertification: To Be	25. Was case referred to medical examiner?  1	nt 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how		Assisted W Living
Division		Certific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in L	ledicai	29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, dea  2 ★ Medicel Exeminer: On the basis of examination and/or is and manner stated.	nvestigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	or with	Σ	29b. Signature and troe of certifier  Shift he look w	29c. License number D22309		pate signed (Month, arch 22, 2	
	rı		30. Name and address of person who completed cause of death (Item 23a) (Type 9013 Flower Avenue Silver		901		
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 3 2004	de			

			1 - State Registrar		epartment of I Certificate of			ene 1. No. 200	4 09149
	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Last)  1-12 PMG S. YEGT  4a. Facility Name (If not institution, give street and number)			or Location of Death		Day Year 21 2004 4c. County of Dec	04:06/JM
	Funeral Director		HOWARD COUNTY GENERAL  5. Social Security Number  6. Sex  1 M 2XXF  Usual Residence of Decedent	ge (In yrs. last birth		MMA - If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Sept. 25	HowA (ear) 9. Bi (1911 Mar	rthplace (State or Foreign
	th the Maryland or 28e-f show e notified at	lirector	10a. State 10b. County  MD Howard  10e. Street and Number	10c. City, Town			10g	. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2√ No ountry?
36	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "naturel", or Itams 23e or 28e-f show event, I're Medical Examinar must be routhed at	by Funeral Director	10910 Hammond Drive  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  10910 Hammond Drive  12. Was Decedent Armed Forces? 1 Yes, Give 18 Yes, Give 19 Year or Dates:	Ever in U.S.	207  13. Was Decedent of Hif Yes, specify Cubin 1 Yes 2 XNo		ecify Yes or No- Rican, etc.)	USA  14. Race - Am Black, Whi	te, etc.
21215-0036	d within 72 hou giene. er then "nature! . I've Medicel E.	Be Completed I	15. Decedent's Education (Specify only highest grade completed)	5+)	Decedent's Usual Occup Give kind of work done life. DO NOT use retired Secretary	pation during most of work d)	Ur	b. Kind of Business niversity Maryland	•
Maryland 21	\$ g in \$	To Be C	17. Father's Name (First, Middle, Last) Frank H. Schloer  19a. Informant's Name/Relationship (Type, Print)	19b. A	Mailing Address (Street	Mary	e (First, Middle, Mai Berger	iden Sumame)	Zip Code)
a)	os 1 and of Health litem 27 rother t		Irene Aldridge/Daughter  20a. Method of Disposition 1	20b. Place of D cemetery,	910 Hammond Disposition (Name of crematory or other place incoln Cem.	(ec	Date 200	20723 c. Location - City or	
Bait	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	M00160	22. Name and Addre	ss of Facility Dor ott Avenu	aldson Fu e, Laurel	neral Ho	me, P.A. 707 Approximate
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as		Y ANTER	L INFAR			Interval Between Onset and Death Hours
3/00,	cate be executed oblysician and the burial-transit	dicai Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as:  c. Due to (or as:  d.	a consequence of):	:				
O. Box 6	Ine law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of del Month	ivery Day Year
records, P	requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but 1. HTPFRTMSON	it not resulting in th	ne underlying cause give	en in Part I.	23e. Did tobacc 1 ☐ Yes	Total Control	the cause of death?
vital Rec	sten: The faw strificate has ctor, page 2 s	Be Completed	25. Was case referred to medical examiner?			26. Place of Death	24a. Was an autopsy performed 1 Yes 24a.	? prior to death?	topsy findings available completion of cause of 2 No
NIVISION OF A	to the robuste of Atlanton Priystolen: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification; To	1 Yes 2 No Hospital: 1 Innerestriction   Hospital: 1 Innerestriction   Hospital: 1 Innerestriction   1 Innerestriction   1 Innerestriction   28a. Date of Injure (Month, Day 2 Accident investigation   1 Innerestriction   1 Inne	v 28b. Time	ne of 28c. Injury	4   Nursing Hor	ne 5 🗆 Residence 8d. Describe how in		cify)
2	t hours after d hours after d uneral Direct bly filled in by	edical Certifi	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Inju building, etc  29a. Certifier (Check only one)  2 ☐ Medical Examiner: On the basis of and many ones characterists.	of my knowledge, de	eath occurred at the time	le date and place a	8f. Location (Street City or Town, St	ate)	etated
)	1	Medi	29b. Signature and title of centifier	Mn, PAC	29c. License	0 935	29d.	Date signed (Month Merch 21	, Day, Year)
	Sta	te	30. Name and address of person who completed cause of de FCROZ A PADOM, 131. Date filed (Month, Day, Year)  32. Registra	r's Signature	pe, Print) SO VAN DUS	EN 20, \$	\$ 1340 LA	URBY M	0 26767.
	Registr		MAR 2 3 2004 Lance	15 B	TOUR!				

		For State Registrar	State of Maryland	/ Department of Health  Certificate of Deat	h	giene 2004 09150
/Me		Decedent's Name (First, Midd     Margaret	Mary Yien	ger  4b. City, Town, or Locatio BALTIM	2. Date of Dea Month	Ath Day Year 3. Time of Death Section 1. Time
p ,		Usual Residence of Decede 1  10a. State 10b. County  BALT  10e. Street and Number  9605 0ak  11. Marital Status	10c. City,  MORE  Ummit Ave.  12. Was Decedent Ever in U.S.	Town or Location  BALTIMORE  10f. Zip Code  212	34.	10d. Inside City Limits 1 □ Yes 2 IX No  10g. Citizen of What Country?
I e, IVICAL YICATION AT INC. 13-0030  S. 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked outber then "naturel, or Items 23s or 28e-1 ehow other transatic event, I'm Medical English at marker rolling at	Completed by Fund	3 □ Widowed 4 □ Divorced	Armed Forces?  ied 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic of If Yes, specify Cuban, Mexic 1 □ Yes 2 No Specifican Give kind of work done during mife. DO NOT use retired.	'y:	Black, White, etc.  Specify: White.  16b. Kind of Business/Industry  At home.
2 should be and Mental is marked of aumatic even	To Be C	17. Father's Name (First, Middle,  Milton (  19a Informant's Name/Relation:  Robert LO.	C. List hip (Type, Print) Lienger		her's Name (First, Middle,	D. Siegfarth.  r. City or Town, State ) Zip Code) 21234.  HITMORE, MD
permit. Pages 1 and Department of Health Importent: if Item 27 any injury or other tr		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (3  21. Signature of Funeral Service	3 Pemoval from State Composity  Licensee  Complications that clusted the death.	netery, crematory or other place)  LLCOD (FM ETERY  22. Name and Address of Fac	3-23-04. BALTIMORE _CHAPEU 88	rest. Approximate
Cate be executed hysician and publician and the burial-transit the burial-transit	er er miner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last	a.  Due to (or as a consequence)  d.	HEA		Interval Between Onset and Death 3 wct/5
w requires that the death certified been signed by the attending phe should be detached for use as the second of t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deal	eath 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
requires that requires that een signed b	Ş	Part II. Other significant conditi	DNS contributing to death but not resulting the HEART DIS	ng in the underlying cause given in Pai	t I. 23e. Did to	bacco use contribute to the cause of death?
Fician: The law rescriticate has been irrector, page 2 sho		DIA BET			24a. Was autop perfor 1 Yes	sy prior to completion of cause of
ng Phy fiter this	Certification: To Be	examiner?	Hospital: 1   Inpatient 2   EF	AVOutpatient 3 DOA Other. 4 Bb. Time of Injury M 28c. Injury at Work?  M 1 Yes 2	28d. Describe h	ience 6 Other (Specify) ow injury occurred  Street and Number or Rural Route Number,
To the Hospitel or Attandi within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	edical Cer	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physicien: To the best of my knowle Examiner: On the basis of examination and manner stated.	edge, death occurred at the time, date n and/or investigation, in my opinion, d	and place, and due to the death occurred at the time, of	cause(s) and manner as stated.  Sate and place, and due to the cause(s)
To 1 with To 1	V	29b. Signature and title of certific	who completed cause of death (Item 2	29c. License numbe	85	29d. Date signed (Month, Day, Year) 3/27/04
	State	31. Dall ARM On 3a 200	32. Registrar's Signatur	817 BELAIR RD	BALTT MO	RE MD 21236

			For State	State of Ma	ryland / D	epartment of the Control of the Cont	Health and M	lental Hygi	ene2004	09151
			* Registrar			Jertincate of	Dealli	Heg	3. No.	
F	Physici /Medic	_	1. Decedent's Name (First, Middle, Las Stella Cather	rine Z	iemlak			2. Date of Death Month March 19		3. Time of Death 8:25 p M
	Examin	er	4a. Facility Name (If not institution, give Good Samaritan Num		er	4b. City, Town, o	or Location of Death		4c. County of Death  n/a	
	Funeral Director		5. Social Security Number 6. Se 220-01-4863	7. Age	(In yrs. last birth	nday) If Under 1 Year Months Days		8. Date of Birth May 20, 1	9. Birth	place (State or Foreign The) y land
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County n/a		10c. City, Town Baltir				1	0d. Inside City Limits
	3 or 286	Il Director	10e. Street and Number 4307 Parkwood Avenue	***		10f. Zip Code 21206		109	g. Citizen of What Cour USA	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marned  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 XN If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub		ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Baltimore, Maryland 21215-0036	within 72 ho ene. than "netur tre Medical I	Completed by	15. Decedent's Ed (Specify only highest gra-			Decedent's Usual Occu 'Give kind of work done life. DO NOT use retire Omemaker	during most of work	ing	Own home	dustry
land 2	uld be filed Mental Hygi irked other ific event,	To Be Co	17. Father's Name (First, Middle, Last) Peter Mead	low			18. Mother's Name Sophie	e (First, Middle, Ma	aiden Sumame) Ihanowski	
, Man	and 2 sho aith and 1 27 is ma er traume		19a. Informant's Name/Relationship (7 Joseph F. Meadow-brot			Mailing Address (Street 1 College Aver				Code)
more	Pages 1 and nent of He sut: If Item		20a. Method of Disposition  1 X Burial 2 Cremation 3 Control of the Specify Survey Sur		20b. Place of cemetery Sacred Ho	Disposition (Name of t, crematory of other pla Bart of Mary	3/25	5/04 [	Dundalk, MD	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Licer	‱ William G	. Dau	22. Name and Address 5305 Harfor	ess of Facility Leo	nard J. Rud imore, MD	ck, Inc. Fune 21214	ral Home
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. End	owellic consequence of	al Car	ng, such as cardiac		st,	Approximate Interval Between Onset and Death
Tec.	Examiner put the property of t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence o					
68760,	eath certificate be executed attending physician and for use as the burial-transit	cal	l	d	consequence of					
P.O. Box	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Fetal death	3 □Ectopic pregnand 5 □ Other (specify)	čy		23d. Date of delive Month	ery Day Year
	w requires that been signed b should be deta	by	Part II. Other significent conditions of	ontributing to death bu	t not resulting in	the underlying cause gi	ven in Part I.	23e. Did toba	cco use contribute to to	he cause of death?
Division of Vital Records,		Completed						24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of
ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one,		
f V	S S	70	1 ☐ Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Out	patient 3 DOA	her: 4 Nursing Ho	me 5 Residen	ce 6 Other (Specif	y)
ion o	Attending Phr r death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Year) 28b. Ti	jury Wo	ry at ork? ] Yes 2 No	28d. Describe how	injury occurred	
Divis	tal or Attencers after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, fari (Specify)	m, street, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	il Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	one;	ysician: To the best o niner: On the basis of and manner stat	f my knowledge, examination and ed.	death occurred at the t for investigation, in my	ime, date and place, opinion, death occuri	and due to the cau red at the time, dat	use(s) and manner as s e and place, and due to	tated. o the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	le		D	se number 28987	3	d. Date signed (Month,	Day, Year)
	18		30. Name and address of poson who dark SPERLING,	Up 560	1 609	Type, Print)  RAYOU	sivo !	BALMYOR	22/2004 RE MD 6	21239
新	Sta		31. Date filed (Month, Day, Year)	32. <b>A</b> 9 istra	r's Signature	fruit;				

State of Maryland / Department of Health and Mental Hygiene 2004 09152 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 11, Day 2004 **Physician** Donald 0830 Wayne Bowser /Medical 4a. Facility Name (If not institution, give street and number)
5937 Quinn Orchard Road 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Frederick Frederick 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 6. Sex 5. Social Security Number **Funeral** 1**⋈**M 2□F Months Days Hours 212-24-1592 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ? is marked other than "natural", or itams 23e or 28e-f show traumatic event, the Medical Examiner must be notified at Maryland Frederick Frederick 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5937 Quinn Orchard Road 21704 U.S.A. Funerai or itams 12. Was Decedent Ever in U.S. Armed Forces? 1 ★★es 2 □ No 1948 to 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itan any injury or other traumatic event, the Medical Examinat once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 1952 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fiance Company Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Luther E. Bowser Mildred R. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia Lee Bowser/Wife 5937 Quinn Orchard Road, Frederick, MD 21704 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory March 12, 2004 Smithsburg, MD 1 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility
Keeney and Basford Funeral Home 21. Signature of Funeral Service Licensee fard M00021 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Celleria MD 21701 Immediate Cause (Final disease or condition resulting in death) SMAN CELL LUNG CANCER Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC ATRIAL FIBRICIATION 1 Yes 2 No 3 Probably 4 Unknown CARDIOMYOFATHY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? PULMONARY HYPERTENSION 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. .

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Datural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifiel 29d. Date signed (Month, Day, Year) 29b. Signature) and title of certifier 29c. License number March 12, 2004 Cornel D31761 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEVENTH STI FREDERICK MD O'CENNEST MD 501 W. BRIAN M. 31. Date filed (Month, Day, Year) 32. Re 32. Registrar's Signature State Registrar

		1	For Stete Registrar	State of Marylan		artment of Health ar rtificate of Death		giene Reg. No. 2004	09153
	Physicia		Decedent's Name (First, Middle, Last)	Theodor I	P. vo	n Brand	2. Date of De Month March	Day Year 15 2004	3. Time of Death
)	/Medic Examin	er 4	a. Facility Name (If not institution, give str 7456 Eylers Valley			4b. City, Town, or Location of I Thurmont		4c. County of Deat Frederic	c County
	Funeral Director		5. Social Security Number 6. Sex 1凶	7. Age (In yrs.	last birthday 76 Yrs.	Months Days Hours	Min. 8. Date of Bir (Month, Da	iy, rear)	hplace (State or Foreign untry) many
	Maryland f show	_	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederick		ty, Town or L armont	ocation			10d. Inside City Limits 1 ☐ Yes 2 💆 No
	with the	Direct	10e. Street and Number 7456 Eylers Valley	Flint Road		10f. Zip Code 21.788		10g. Citizen of What Co	·
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show empty injury or other traumatic event, I'm Marical Examinar must be nutified at once.	by Funeral Directo		2. Was Decedent Ever in U Armed Forces? 10	1.s. 945- 947	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	rithin 72 hounge.	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed)  College (1-4or 5+) 5+	(Give	dent's Usual Occupation b kind of work done during most of DO NOT use retired) nistrative law		16b. Kind of Business. US Departme	Industry nt of Labor
N	should be filed wand Mental Hygiers marked other thumatic event, III	To Be Cor	17. Father's Name (First, Middle, Last) Theodor C. von Bra			18. Mother's	s Name <i>(First, Middle</i> arethe Bra	, Maiden Sumame)	
Maryland	d 2 shou th and M 7 is mar traumat		19a. Informant's Name/Relationship (Type Shirley M. von Bra			ing Address (Street and Number Eylers Valley			
Baltimore,	Pages 1 and 2 nent of Health a int: If item 27 is iry or other trau	1	20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	movel from State	cemetery, cri	osition (Name of pmatory or other place) rg Crematorium	March 16 2004	20c. Location - City or Smithsburg,	
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Service License	turn	2	2. Name and Address of Facility 10 West Main St	reet Emmi	tsburg, MD	21787
8760,	The law requires that the death certificate be executed with the West of the attending physician and with the steen signed by the attending physician and with the steen signed be detached for use as the burial-transit	lical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		quence of):	na of the Pros			Interval Between Onset and Death
P.O. Box 6	the death certifica the attending ph ched for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	Sc. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
	quires that the de n signed by the a uld be detached t	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the	underlying cause given in Part I.		tobacco use contribute to Yes 2 No 3 □ P	o the cause of death?
of Vital Records,		Completed					24a. Was auto peri 1 🗆 Yes	opsy prior to death?	utopsy findings available completion of cause of s 2 \(\sigma\) No
Vita	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2[	☐ ER/Outpati	Other	of Death (Check only sing Home 5 Res	one) sidence 6 □Other (Spe	ecify)
Division of	ding 7. After fune	Certification: T	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Work? M 1 ☐ Yes 2 ☐ N	0	how injury occurred  (Street and Number or R	iural Route Number
DIV	tel or Attencis after death	Certifi	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, tarm, s	treet, factory, office		own, State)	oral Proble Portion,
	To the Hospitel or Attenwithin 24 hours after deall To the Funerel Director: completely filled in by the	edical	(Check only 2 Medicel Exemination)	er: On the best of my kner: On the basis of examinand manner stated.	nowledge, de nation and/or	ath occurred at the time, date and investigation, in my opinion, death	place, and due to the coccurred at the time	, date and place, and du	e to the cause(s)
	Tot with Tot	Σ	29b. Signature and title of certifier	265		29c. License number	29	March /	
_	1011		30. Name and address of person who co	accim.D 4	161 Nor		, Balhin	nere MD 2	1231
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 2 3 20	32. Registrar's Sig	nature	Carles .			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) MARCH 1 2 2004 **Physician** RALPH S. BURDICK 7:40 Рм /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Name (If not institution, give street and number) Examiner ROCKVILLE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
AUG 31 SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY 5. Social Security Number 6. Sex/ 1 M 2 F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1924 WASH. 577-20-3340 79 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at MD MONTGOMERY DICKERSON 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21420 PEACHTREE ROAD 20842 USA 23a Completed by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Arméd Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 √Yes 2 No 1943-1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 0 If Yes, Give Year or Dates: 1946 1 Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONTRACT SPECIALIST FED. GOVERNMENT 5+ Pages 1 and 2 should be filed vitner of Health and Mental Hygie tant: if item 27 is marked other i jury or other treumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be BERNARD F. BURDICK LILLIAN SMITH 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREGG BURDICK / SON 21418 PEACHTREE RD., DICKERSON, MD 20842 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or GATE OF HEAVEN 3/20/2004 SILVER SPRING, MD 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE 20838 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE HOURS /Medical resulting in death) Due to (or as a consequence of) **Examiner** SEPSIS DAYS Sacuantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine sicion and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 6876 Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Ö Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by ARRHYTHMIAS, CARDIAC 2 1 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 No 1 ☐ Yes 2 No 1 Yes Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after 4 Momicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00057954 March 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN, MD 9901 MEDICAL CENTER DR., ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		٠	1 - For State Registrar	State of M	arylan	d / Depa	artment <i>rtificate</i>	of He	ealth a Death	and M		giene Reg. No		4 0915
	Physic		1. Decedent's Name (First, Middle, La Lillian I Bieber	st)							2. Date of De Month MAR(	Da	y Yea 16, 200	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give Saint Joseph			ter '	4b. City, To	own, or l		f Death			. County of De	
	Funeral Director			ex 7. Ag □ M 2□ F 9		last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min	8. Date of Bir (Month, Da Septembe	v. Year	9. Bo	irthplace (State or Foreign Country) Ston, Mass.
	Maryland a-f ehow	tor	Usuel Residence of Decedent  10a. State  10b. County  Maryland  Baltimore			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28s	I Director	10e. Street and Number 25 Henry Avenue				10f. Zip C					10g. Ci	tizen of What (	Country?
9036	should be filed within 72 hours after death with the Maryland of Mental Hygiene, marked other than "natural", or items 23a or 28a-f show imatic event, the Madical Exercities in the results of the madical Exercities at the results of the madical exercities at the results of the madical exercities at the madical exercities of the madical exercities at the madical exercities of the	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Tes 2 1 If Yes, Give Year or Dates:	,		Was Deceder f Yes, specify	/ Cuban	panic Orig , Mexican, Specify:	gin? (Spec , Puerto P	cify Yes or No lican, etc.)	_	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	filed within 72 h Hygiene. other than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or !  VA	5+)	16a. Deced (Give life. I	dent's Usual kind of work DO NOT use	Occupat done du retired)	ion uring most	of workin	g		and of Busines	s/industry 2-Own Hame
ryland	e d a b	To Be	17. Father's Name (First, Middle, Last) Albert George Ilse  19a. Informant's Name/Relationship (			10h Mailie	a Addross (f	]	Larise	Augur	(First, Middle, Ste Holz	apfe.		7.0.41
	1 and 2 a Health ar em 27 is ther trau		Farl L Swartzendruber 20a. Method of Disposition		20b. P	25 Her	iry Aven	ue l	Baltim		Maryland	21.2		
Baltimore,	nit. Pages artment of l ortant: If it injury or o	3	1	<i>'</i> )	I	emetery, cren kwood Ce	-	Marc	ch 22			Balti	imore,M a	aryland
ñ E	permit. Depart Import any inj		23a. Part1. Enter the disease, or com	olications that caused	the death	1 14	issahn H 01 Bela	unera ir Ro	al Hom bad B	e Inc altim	ore, Mar	ylan: rest,	1 21236	Approximate
8/60, 0	certificate be executed with the project of the purish transit is as the buriat-transit is as the buriat-transit is as the purish transit is a purish transit is as the pur	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. CONGES  Due to (or as  CORONA  Due to (or as  c. Due to (or as  d.	TIVE a consequ IRY F a consequ	uence of): ARTERY uence of):								Interval Between Onset and Death
O. Box 6	the death certif y the attending iched for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic preg						23d. Date of de Month	Blivery Day Year
ecords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of		ut not resu	ulting in the un	iderlying caus	se given	in Part I.			bacco u		o the cause of death?
r	The law ate has b page 2 st	Completed	CHOLECYSTITIS						. <del></del>		24a. Was a autop perfor 1 Yes	sy	prior to death?	utopsy findings available completion of cause of
Division of Vital	or Attending Physician: Thater death. Director: After this certificate in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1		ry y Year)	ER/Outpatient 28b. Time of Injury me, farm, stre	28c.	Other: Injury a Work? 1  Ye	4 🗆 Nurs	sing Home 28	d. Describe h	ence (ow injur	d Number or R	ural Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Exam	vsician: To the best of iner: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred at t estigation, in	he time, my opin	date and lion, death	place, an	d due to the c	ause(s) ate and	and manner a place, and du	s stated. e to the cause(s)
	To th withir To th	Me	29b. Signature and title of confier	and the second	040	3	D	icense n			2	19d. Dat	1 16 C	
	Sta Registr	100	30. Name and address of person who of BOON F's LIM Ms.  31. Date filed (Month, Day, Year)		OSLE	R DRI	,	)WSC	IN ME	ARYL.	AND 2	120	4	

			For	State of Marylan	nd / Depa	artment of H	lealth an	d Mental Hy	giene	2001	0015/
			1 - State Registrar		Cei	tificate of I	Death		Reg. No.	2004	
DI	nysicia	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
4-1	Medic	al	Alice 4a. Facility Name (If not institution, give st	Cusick		4b. City, Town, o	r Location of D	Februar		2004 County of Death	5:15 P <sup>M</sup>
E	xamin	er	10461 Waterfowl Te				mbia	00011		Howard	
Fu	neral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Bir Min. (Month, Da			place (State or Foreign
	ector		216 32 8107	M 2K) F 81	Yrs.	Months Days	Tiodis	May 1	192		zland
pue ;	1		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	10d. Inside City Limits
Maryli	e tra	Į.	MD Howard		Columbi						1 ☐ Yes 2 No
ett c	The state of	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cour	ntry?
th with	258 0	alD	10461 Waterfowl Te	rrace		2104				nited St	
e dea	EL TI	uner	Tr. Maritar Otatos	<ol><li>Was Decedent Ever in U Armed Forces?</li></ol>	I.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin' an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	o- 1	<ol> <li>Race - America</li> <li>Black, White,</li> </ol>	
rs afte	Marrier 1	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 ∑No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:			Specify:	nite
2 hou	SalE	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	ation	warting	16b. Kir	nd of Business/In	
thin 7	Madi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	working			
be filed within 72 hours after death with the Maryland tall Hygiene.	d other than "natural, or tems 2.5a or 20ari shuw event, the Madical Examinat must be indiffed at		unknown		Hou	ıse Clean		Name (First, Middle		Self Emp	<u>oloyed</u>
ylallo ould be fii Mental H	p 6	Be.	17. Father's Name (First, Middle, Last) Henry L. Cusick				_	L. Bennet		Sumame)	
2 should and Mer	marked matic ev	ပ္	19a. Informant's Name/Relationship (Typ	De, Print)	19b. Maili	ng Address (Street		r Rural Route Numb		Town, State, Zip	Code)
d 2 d d d d d d d d d d d d d d d d d d	item 27 is marke other traumatic		Susan Johnson/Frie	nd	9534	Many Mil	e Mews	Columbia,	MD	21046	
ss 1 an	r othe		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation 3 ☐ Re		Place of Dispo	osition (Name of matory or other place		Date		cation - City or To	
Page	ury o		* 4 ☐ Donation 5 ☐ Other (Specify)	Me		rematory		-7-2004	_	onsville	
partificate, permit. Pages 1 and Department of Healt	any in		21. Signature of Funeral Service License	- Wille							lly FH Inc. MD 21043
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	eations that crused the dear	th. Do not ent	er the mode of dyin	ng, such as car	rdiac or respiratory a	rrest,		Approximate Interval Between
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	dical niner		resulting in death)	Due to (or as a consec		3.					4.0
_Au.		Ā	Sequentially list conditions, b.	Arterioscle		cardiac	disease	9		8	40 years
petn .	ansit	Examine	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
<b>be</b> executed	an an rial-tr		resulting in death) Last	Due to (or as a consec	quence of):			-			
S/OU, ate be ev	attending physician and for use as the burial-transit	lcal	d.								
death certifical	ding b	Physiclan/Med	IF FEMALE: 23	3c. If yes, outcome of pregn	ancy				2	23d. Date of delive	arv
BOX Beath cer	atten I for u	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	□Ectopic pregnancy □ Other (specify)	y 			Month	Day Year
j 🖺	by the	hysi	9 Unknown	9□ Unknown							
ecords, P.O.	been signed by the should be detached	by P	Part II. Other significant conditions con		sulting in the u	inderlying cause giv	ven in Part I.				he cause of death?
ordanine equir	sen si	ted	Mitral Valve repla	cement				- 1	Yes, 25	XNo 3 □ Prot	bably 4 Unknown
VITAI KECOFOS, sician: The law requires t	hasb e2st	Completed						- 24a. Was	DSV	24b. Were auto prior to co death?	opsy findings available impletion of cause of
<b>교</b> 를 :	certificate has lirector, page 2 s								ormed? 2 ☐ No	1 🗆 Yes	2 🖾 No
VII	r this certifica	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	lospital: 1  Inpatient 2	] ER/Outpatie	nt 3 DOA Oth		Death (Check only ng Home 5 XRes		Other (Special	fv)
- O	0 0	<del> </del>	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at	28d. Describe			,,
sath.	or: After he funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	[, 22,,	,,		Yes 2 □ No				
DIVISION of or Attending after death.	Direct 1 in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office		28f. Location ( City or To	(Street and wn, State)	d Number or Rura )	al Route Number,
DIVISION Of VITA To the Hospitel or Attending Physician: within 24 hours after death.	Funeral	Medical C	29a. Certifier Certifying Phys	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	th occurred at the til	me, date and popinion, death o	place, and due to the occurred at the time,	cause(s) , date and	and manner as s place, and due to	stated. o the cause(s)
o the	ro the	Mec	29b. Signature and title of certifier	fail -		29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)
<b>⊢</b> \$	-0		No Den 1/1/	Musus M.	D	D36	246		3/	8/04	
			30. Name and address of person who co				1-1- 30	21044		/	
			Robert W. Olwine M 31. Date filed (Month, Day, Year)	ID 4994 Beave:		ra Colum	pla, M	J Z1U44			
	St: Regist	ate rar	31. Date filed (Month, Day, Year)	2004 Degistrar's sign	e A	fred s	٧				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2001

	•	-	For State Registrar	State of Ma		ertificate of D			g. No.	1 03121
			Decedent's Name (First, Middle, Last	st)				2. Date of Death Month	1	3. Time of Death
	√ Physicia /Medic		WILLIAM	D. 1	EVANS			March	05 20	04 11:45 P.M
	Examin		4a. Fecility Name (If not institution, give			4b. City, Town, or L			4c. County of De	
			4011 Crisf  5. Social Security Number 6. S		'ay e (In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth (Month, Day,		irthplece (State or Foreign Country)
	Fugneral Director	-		<b>⊠</b> M 2□ F	63 Yrs.	Months Days	Hours Min.	March 4,	1941 Ma	aryland
	ow et	-	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Man)	ţoţ	Maryland Somer	set		Cris	field			1 ☐ Yes 2 ☒ No
	or 28	Olre	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	-
	s 23s	ral	3277 Boone Road	12 Was Decedent I	Ever in U.S. 12		1817	pecify Yes or No-	USA 14. Bace - Ar	nencan Indian,
920	be filed within 72 hours after death with the Maryland stal Hygiene. Indicate than "naturel", or items 23e or 28e-f show event, the Madical Examiner must be notified at event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12, Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	ietnam Era	J. Was Dacedent of His If Yes, specify Cuban 1 ☐ Yes 2 🕱 No		Rican, etc.)	Black, Wi	
2-0	72 hor	sted	15. Decedent's E	ducation	16a. Dec	edent's Usual Occupat re kind of work done du DO NOT use retired)	ion iring most of work	ing	8b. Kind of Busines	
Maryland 21215-0036	C 100	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)			"	J. S. Depa Commerce	artment of
d 2	filed withii Hygiene. other than		17. Father's Name (First, Middle, Last,	)	Malin	enance Sup		e (First, Middle, N		
an	ld be ental ked o	To Be	William H. Evans				Georgia	Virginia	Mears	
ary	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	iling Address (Street ar	nd Number or Rui	al Route Number,	City or Town, State	, Zip Code)
			Judy L. Evans (Wi	fe)		77 Boone Ro				
Baltimore,	permit. Pages 1 end Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery, ci	position (Name of ematory or other place	)		20c. Location - City	
Itim	permit. Pages Department of Important: If it any injury or o	· ·	<ul> <li>4 □ Donation 5 □ Other (Specif</li> <li>21. Signature of Funeral Service Licer</li> </ul>		Sunnyridge	e Memorial Pai 22 Name and Address				, Maryland
Ba	permit. Departr Importa any inji		Mary Beth Bro	adshaw-Fru		<sup>22</sup> Name and Address Bradshaw 8 306 W. Mai	n Street	t - Crisf	field, Man	yland 21817
ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	I the death. Do not e ne.	nter the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
A	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	LTIPLE IN	JURIES				
	Examiner				a consequence of):					
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5	and and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
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	tificate og phy as the	ledical								
.O. Box	requires that the death ceatificate be executed een signed by the attending physicien and nould be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	Control of the contro			23d. Date of o Month	lelivery Day Year
۵.	uires that the di signed by the id be detached	by	Part II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying cause give	n in Part I.			to the cause of death?  Probably 4 Dunknown
Records,	as b	Completed						24a. Was ar autopsy perform X Yes 2	prior to death	autopsy findings available o completion of cause of ?
ital		Be C	25. Was case referred to medical				26. Place of Dea	th (Check only one		
) \ \	Physicians this certific ral director,	To	examiner? 1 XYes 2 No	Hospital: 1   Inpatie			4   Nursing H		nce 6X Other (S	oecity) Scene
Division of Vital		:lou:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	28b. Time (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	/ Work		28d. Describe ho	winjury occurred in auto	accident
isic	Attending er death. rector; After by the fune	flcat	3 Suicide 6 Could not b	e 28e. Place of Inj	ury - At home, farm,	51.	223.10			Rural Route Number, ield, MD
Ο̈́	rs after s after el Dire ed in b	Certification:	4  Homicide determined	building, et	c. (Specify)	treet			isfield H	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	edical			f examination and/or	ath occurred at the time investigation, in my opi				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	11		29c. License	number	29	d. Date signed (Mo	nth, Day, Year)
				Comb		0.C	M.E.		March 7,	2004
	20		30. Name and address of person who J. Laron Locke M			e, Print) <b>Penn Stree</b> t	- Pa1+4	more Mar	ryland 21	201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature			INTE, FIG	-J	
	Regist	ar	MAR	2 3 2014	Bestone.	de decelle	- B			

DHMH 17 Rev 1/2001

Alexand St.

			For State	State of M	aryland		artment of H			giene 20	04	09158
			Registrar  1. Decedent's Name (First, Middle, Li	ast)					2. Date of Dea	ith		3. Time of Death
п	Physici			Á.	Fe	eney			Month MARCH	Day 11 200	Yeer	0330 M
	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of Death	THINOU	4c. County		10330
	LAGITIII	Ç.	MEMORIAL HOSPIT	ΓAT.			CUMBERL	AND		ALLEG	ANY	
	Funeral			Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Aug 28	Year)	9. Birth	place (State or Foreign
Ш	Director		217-10-4396	1 □XM 2 □ F	87	Yrs.	Months Days	riours ivini.	Aug 28	3, 1916		M/D
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or La	postion					I Od. Inside City Limits
	anyla shov	~	MD Allega	any	Too. Oity		berland				'	1 XYes 2 ☐ No
	288-1	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cou	ntn/2
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23s or 28e-f show ent, the Mydical Esaici, art must be notified at	ă	730 Furnace Stre	et .				21502		-	SA	
	ns 23	by Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.1			ecify Yes or No-			can Indian,
	ter d	Ë	1 Never Married 2 Married	Armed Foresco	?	1	Was Decedent of H If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)		k, White,	
336	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII		1☐ Yes 2☐No	Specify:		Specify	whi	te
ŏ	2 hoi	Completed	15. Decedent's 8				dent's Usual Occup- kind of work done of		ein a	16b. Kind of Bu	siness/In	dustry
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7	gien gien er th	Con	12			Posta	l Worker			U.S. Po		Service
p	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las					18. Mother's Nam	(Laing)	Maiden Sumam	Θ)	
₹ Z	should be nd Mental marked c	ို	Patrick L. Feer						`			
Baltimore, Maryland 21215-0036	d 2 th a 7 to		19a. Informant's Name/Relationship Bill Feeney	nepl	hew	621	ng Address (Street a Montgom	nery Aven	ue Cumb	perland	State, Zip MI	D 21502
ore,	of He of Herr		20a. Method of Disposition  1	□ Bamousi from State	Ce	metery, crer	sition (Name of matory or other place	(e)	Date	20c. Location -	•	
Ĕ	Pages nent of I ant: If the		`4 □Donation 5 □ Other (Spec		SS	Peter P	aul Cemete	ry	3/13/2004	Cumbe	erland	d <b>M</b> D
Balt	permit. Pages 1 an Department of Heali Importent: If tem 2 any injury or other once.		21. Signature of Funeral Service Lice	7 Alv	ell	( 22	Names nd Addres 108 Vire	ifi rFuneral H ginia Avenu		rland. MD	21502	2
ř	1 SE		23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that cause	d the death	. Do not ent						Approximate Interval Between
	Physician		Immediate Cause (Final	BILATE							3	Onset and Death DAYS
	/Medical		disease or condition resulting in death)	Due to (or as					· · · · · ·			
	Examiner			b								
Æ	THE STATE OF THE S	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):						
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P	e exe ien au urial-1	EX	resulting in death) Last	Due to (or as	a consequ	ence of):						
8760	cate be executed physicien and the burial-transit	Physician/Medical		d								
9	The law requires that the death certific tite has been signed by the attending p page 2 should be detached for use as	Med	IF FEMALE:									
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3	Ectopic pregnancy			23d. Dat Mor	e of delive nth	ery Day Year
o.	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant a 9⊡Unknown	it time of de	eath 5	Other (specify)					
<u>o.</u>	that the de led by the detached		Part II. Other significant conditions	contributing to death t	out not resu	ilting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use conti	ibute to the	ne cause of death?
ds,	signe d be	d by	DEMENTIA				, ,		1 🗆 Y	es 2□No	3 Prob	pably 4 Munknown
Ö	w requir been si should	ete	17 11 11 11 11 11 11 11 11 11 11 11 11 1						24a. Was	24h V	Moro auto	more findings qualishin
3ec	has has	Completed							autop	med?	rior to co leath?	psy findings available mpletion of cause of
al	n: Th icate r, pag			T						2 <b>X</b> No 1	Yes	2 No
Vital Records,	sicial certif	Be	25. Was case referred to medical examiner?	Hospital:	00	ER/Outpatier	t 3 DOA Oth	er: 4 D Number 14	me 5 ☐ Resid		/0	
of	Physical distribution	: To	1 ☐ Yes 2 📉 No  27. Manner of Death	28a. Date of Inju	ury	28b. Time of	11 3 DOX	4   Indianing no	28d. Describe h			у/
on	ding Ith. th. After funer	ig l	1 Natural 5 ☐ Pending 2 ☐ Accident Investigati	(Month, Da	ay Year)	Injury		k? Yes 2 □No				
Division	Attending Physician: I death. ector: After this certific by the funeral director,	ifica	3 Suicide 6 Could not	be 28e. Place of In	jury - At ho	me, farm, str	eet, factory, office		28f. Location (S	treet and Numb	er or Rura	al Route Number,
á	al or	Certification:	4 Homicide	building, e	tc. (Specify	')			City or Tow	n, State)		
	To the Hospitel or Attending Physicien: The lawithin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical (		Physician: To the best aminer: On the basis of and manner si	of examinat							
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed	(Month,	Day, Year)
)	->		•	Like	حور		200	33280		March	1)	2004
	1-		30. Name and address of person wh	o completed cause of	death (Item	23а) (Туре,		-			/_	
	Ψ		DR.SUNIL GUPTA 6	25 KENT AV	ENUE,	SUITE		BERLAND,	MARYLANI	21502		
	Sta Regist		31. Date filed (Month, Day, Year)	MAR 2 5 2	rar's Signat	ure	Carlo S. All	1246				

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No:-2. Date of Death 1. Decedent's Name (First, Middle, Last) March 05 05 2004 **Physician** CHRISTOPHER 11:45 P.M FISHER G. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Samerset 4011 Crisfield Highway Crisfield If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Months 1⊠M 2□F Yrs. 32 December 6, 1971 Maryland 280-72-8087 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State irel", or items 23s or 28s-f show Examiner must be notified at 1 ₹ Yes 2 No Director Maryland Crisfield Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 48 Maryland Avenue 21817 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced ar then "natur. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. Construction Worker General Contractor of Health and Mental Hygie litem 27 ie marked other I r other traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Christopher C. Fisher PattiAnne Page 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher C. Fisher (Father) 26590 Mariners Road - Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 0 = 0 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or Asbury/Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 3/11/04 Crisfield, Maryland 22. Name and Address of Facility Bradshaw & Sons Funeral Home 21. Signature of Funeral Service Ligensee Costanty
Mary Jeth Bradshaw-Pruitt 306 W. Main Street - Crisfield, Maryland 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEAD AND CHEST INJURIES **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ίο in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1X Yes 2 \sum No autopsy performed? Yes certificate 2 🗆 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Scene To Director: After this in by the funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 11:35 PM 3/5/04 occupant in auto accident 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 4011 Crisfield Highway Crisfield, MD street filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and due to the cause(s) 2 Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier O.C.M.E. March 7, 2004 Camo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 J. Laron Locke M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 23 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Vear George 1.55 **Physician** Folmar Edward March 15 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany Cumberland Memorial Hospital 7. Age (In yrs. last birthday) II Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 3, 1940 9. Birthplace (State or Foreign 5. Social Security Number **Funeral X**□M 2□F Hours Months Days Vrs 546-54-7349 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "naturel", or Items 23a or 28e-f show the Medical Examinar must be notified at 1√□Yes 2□No MD Allegany Cumberland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 902 Swick Lane 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No KYes, Give Year or Dates: 1958-1960 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) oit. Pages 1 and 2 should be filed within purtnent of Health and Mental Hygiene. Certent: If item 27 Is marked other than injury or other treumatic event, the Mental or other treumatic event, the Mental or other treumatic event. Elementary/Secondary (0-12) Pipe Installation Quality Control Inspector 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anna Bridget Folmar George Christopher Folmar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 902 Swick Lane Cumberland MD 21502 Mary Folmar wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 3/16/2004 Scarpelli Funeral Home, P.A. MD Cresaptown \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA mpor iny in 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiomo Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate case. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 10 No 2 PNo 26. Place of Death Check onl one 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 DER/Outpatient 3 □ DOA After thi 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 | Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29c. License number 29b. Signature and title of certifier 00056207 Kuramforman, M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL CUMBERLAND, MD 21502

DHMH 17 Rev 1/2001

State

Registrar

HEART

SACRED

HUSAM SEMAAN, M.D.

MAR 23 2004

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 20009161 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Year **JERRY** 10:49 am MARCH HARTMAN 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 135 N. Mechanic St. Cumberland **Allegheny** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 24,1937 Birthplace (State or Foreign Country) **Funeral** Months **1**℃M 2□F 214-34-2171 66 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "netural", or items 23a or 28e-f show the Medical Examinat must be notified at MD Allegheny Cumberland Y□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 N. Mechanic St. 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2□No IfYes, Give Year or Dates:1954-59 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□Yes Z No þ Specify: White 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cabinet Maker Cabinet Company permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiei Important: If item 27 is marked other 11 any injury or other traumatic svent, the once. GED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mellvin Louis Hartman GRACE IODA RAINES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald L. Hartman 102 Whetstone St., Hyndman, PA 15545 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 13, N Burial 2 ☐ Cremation 3 ☐ Removal from State Ebenezer Cemetery '4 ☐ Donation 5 ☐ Other (Specify) 2004 Romney, WV 21. Signature of Funeral Service Licensee SHAFFER FUNERAL HOME 22. Name and Address of Facility 230 E. MAIN ST., ROMNEY, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNKNOWN ARTERIOSCLEROTIC HEART DISEASE /Medical Due to (or as a consequence of): Examiner UNKNOWN DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): igned by the attending physician be detached for use as the buria Division of Vital Records, P.O. Box 68760 Certification; To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COPD cate has been signate, page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner?

1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Till Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D09157 March 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow; 137 W. Third ST., Cumberland, Maryland 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0<sup>Month</sup> Ogy **Physician** 2004 VIOLA LUCILLE HARSH 12:25PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GARRETT OAKLAND CUPPETT WEEKS NSG. HOME 7. Age (In yrs. last birthday)

8.4 Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 6 (Months Day) | 9 (Months Days Hours Min. | 6 (Months Days Min. | 6 (Mont 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Director 232-56-4760 AURORA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28e-f show The Medical Examiner must be notified at WV PRESTON AURORA 1 ☐ Yes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA RT. 1, BOX 167 26705 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status e filed within 72 hours after at Hygiene. other than "natural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify HITE φ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If Item 27 is marked other thany injury or other traumatic event, Impore. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) DONA PEARL HENLINE JOHN LEONARD SNYDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT. 1, BOX 167 AURORA, WV WILDA BLAMBLE/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State ACCIDENT CEMETERY 3-12-2004 EGLON, WV ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fufferal Service Licenses HINKLE FUNERAL HOME PO BOX 186. DAVIS WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician acute cerebrovascular accident 15 wks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2**X**□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: X Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attanding 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di completely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature, and title of certifier D30035 03-09-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald Richter, M.D. 1533 Memorial Drive Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Re 32. Registrar's Signature State Registrar

-01 <sup>°</sup>	/38		- State Unpend Item#23a,2				Health and N	•		09163
	Physici	an	1. Decedent's Name (First, Middle, Last)				Douin	2. Date of Death	Day Year	3. Time of Death
	/Medic Examir	al .	CRAIG  4a. Facility Name (If not institution, give s	EDWARD treet and number)	Н	ARRIS  4b. City, Town,	or Location of Death		9, 2004 4c. County of Deeth	0229 A M
J			Aiken Avenue at Pu			Perryv			Cecil	
23	Funeral Director		5. Social Security Number  215-80-6384  Usual Residence of Decedent	M 2 F	47 Yrs.	Months Days		8. Date of Birth (Month, Day, 11/19/	Year) 9. Birthp Coun 1956 Mar	ace (State or Foreign try) yland
	death with the Maryland ms 23s or 28s-f show	tor	10a. State 10b. County  MD. Ceci		c. City, Town or Lo	ocation	Perry	ville	11	0d. Inside City Limits 1 ☐ Yes 2 📉 No
	vith the Ma or 28a-f	Director	10e. Street and Number			10f. Zip Code	07.005	10	g. Citizen of What Coun	
	eath w	Funeral	700 Carter Co		pt. D	Was Decedent of I	21903 Hispanic Origin? (Sr	pacify Yas or No-	United S	
980	ours after d el', or Iten Examenac	þ	1 ANever Married 2 Married 3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever Armed Forces?</li> <li>1 ☐ Yes 2 No If Yes, Give Year or Dates:</li> </ol>		If Yes, specify Cub 1 ☐ Yes 2 🙀 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, White,	
Maryland 21215-0036	be filed within 72 hours after ital Hygiene. Id other than "natural", or Ite event, the Mydigal Examera	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give		during most of work ad)	king	6b. Kind of Business/Inc	·
121	iled will have the there the		12 17. Father's Name (First, Middle, Last)	0	Respi	ratory	Therape	utist e (First, Middle, M	Health Ca	re
yland		To Be	William	Emmett	Harri		Ida	Mil	dred	Gill
			19a. Informant's Name/Relationship (Type William E. Harr 20a. Method of Disposition 1 □ Burial 2 ★Cremation 3 □ R	is Sr./	360	ng Address (Street  2 Harri  position (Name of matory or other pla	s Lane	Jarre	City or Town, State, Zip  ttsville,  Oc. Location - City or To	Md.
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other trongs.	; G	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeran Sent ce Licen	~ ) (	2:	2. Name and Addre	ess of Facility J	arretts	Hampstead ville, Ma ral Home,	ryland
68760,	Physician /Medical Examiner  the purial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on shock, or heart failure. List only on the second of the second o	Multiple In	juries onsequence of): onsequence of):	ter the mode of dyi	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
P.O. Box 6	Attending Physician: The law requires that the death certifical or death.  r death. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of p  1 ☐ Live birth 2 ☐  4 ☐ Pregnant at time	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deliver Month	ry Day Year
rds, P.	w requires that the second of		Part II. Other significent conditions con	tributing to death but no	ot resulting in the u	inderlying cause gi	ven in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
Vital Records,	i: The law re cate has bee r, page 2 sho	Completed						24a. Was an autopsy performe 1X Yes 20	prior to com death?	sy findings available inpletion of cause of
of Vit	hysiciar his certif il directo	To Be	MCX162 2 140	ospital:	2 ER/Outpatier	IL 3D DOA	ner: 4 🗆 Nursing Ho		ce 6 Other (Specify,	At scene
ono	iding P th. : After t	tion:	27. Manner of Death 1 □Natural 5 □ Pending 2 ☑Accident investigation	28a. Date of Injury (Month, Day Ye 3/9/04	28b. Time o Injury 2:25	Wo	rk?	28d. Describe how	injury occurred  struck by moto	r vehicle
Division of	or Atter fter dea Director in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str			28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	ician: To the best of mer: On the basis of exa	y knowledge, deat amination and/or in	h occurred at the ti	me, date and place,	and due to the cau	nd Pulaski Hwy se(s) and manner as sta e and place, and due to	ited. MD
	To the within ?	Med	29b. Signature and title of certifier	and mainles stated.	100	29c. Licens	se number	290	d. Date signed (Month, D	Pay, Year)
			Hatulle	on-to	Slel.	o.c	.M.E.	M	March 09, 20	004
	5		30. Name and address of person who co	1. CA- 10	1/AKus 1		Street, B	altimore,	Maryland 2	21201
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's 2 3 2 204		1 Ass	100			

				State of Mar	yland / Depa	artment of H	Health and I		giene		
			1 - For State Registrar		Ce	rtificate of	Death	,		004	0916
	Physici /Medic		1. Decedent's Name (First, Middle, Las David	<sub>")</sub> James Harla	n, Sr.			2. Date of Dea Month March	Day	Year 004	3. Time of Death O854 A M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat	h	4c. County	of Death	
			Union Hospital			Elkton			Ceci	il	
	Funeral Director		220-24-5440	9x ∑M 2□F 7. Age (	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birtl (Month, Day March 20	, Year) , 1928	Country	nce (State or Foreign y) 'land
	and *		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	ocation				100	d. Inside City Limits
	Aaryl Feho	ō	M1		•						1⊠Yes 2□No
	286-	Director	Maryland Cecil  10e. Street and Number		Elkton	10f. Zip Code			10g. Citizen of V	What Countr	v?
	With The					21921				ed Sta	•
	ms 2	Funerai	102 Clark Street	12. Was Decedent Ev	er in U.S. 13.		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-		e - American	
Maryland 21215-0036	d within 72 hours after death with the Maryland jene. r than "naturel", or Items 23s or 28e-f ehow the Madical Examinet must be notified at	by Fur	1 ☐ Never Married 2 ☐XMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 XYes 2 No If Yes, Give Year or Dates: 7	1950 to .956	If Yes, specify Cub 1 ☐ Yes 2 🂢 No		o Rican, etc.)	Specify Specify	k, White, etc Whi	
Š	2 hou	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu		
215	hin 7.	pie	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of word)	rking			•
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멀	al Hygie I other vent,	Be (	17. Father's Name (First, Middle, Last)					ne (First, Middle,		e)	
Na Na	should be nd Mental marked o	2	Amos Harlan, Sr.				Helen S	Singleto	n		
an.	2 shouk and Me is mark raumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip C	Code)
	1 end 2 Heelth 1em 27 l		Maria Harlan/Wif	e		- TOTAL - SECTION	eet, Elki		A		
ore	Peges 1 end 2 should be filed nent of Heelth and Mental Hyg ant: If Item 27 is marked othe ary or other traumatic event,		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo Gilpin M	sition (Name of matory or other plai anor	ce) Marc	ch 17,	20c. Location -	City or Towr	n, State
Ë	nit. Per partment ortant: injury		`4 ☐ Donation 5 ☐ Other (Specify		Memorial	Park	2004	1	Elkton,	Mary	land
Baltimore,	permit. Peges 1 en Department of Heel Important: if Item 2 eny injury or other ance.		21. Signature of Funeral Servi & Licen				ss of Facility for Fune				
A.	40204		222 Part I Foto the disease or come	J. J.	1(	3 W. Sto	ckton Sti	ceet, Ell	kton, Ma		ad 21921 Approximate
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Refrac.	tory Hy	16 Kens		or respiratory arr	631,	In	nterval Between Onset and Death
S.	Examiner		1	Due to (or as a d	consequence of):	Polmona	F. 1	10801		7	Weeki
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	onsequence of):	1 07-404 2	7	7,0161			weeks
$\cap$	te be executed ystcian and ie buriat-transit	Examiner	Cause (Disease or injury that initiated events	C						- 1	
0	be executed ician and burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):					j d	
3760,	ate be	cai	(	d							
x 68	that the death certificate ed by the attending phys detached for use as the	Physician/Medi	IF FEMALE:	00. 14							
Вох	ath catternation us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 [	Fetal death 3	Ectopic pregnancy	/		23d. Date Mon	e of delivery oth Da	
o.	the de	ysic	1 Yes 2 No	4☐Pregnant at tin 9☐ Unknown	ie or death 5L	Other (specify) _					
Ο.	that the ded by detac		Part II. Other significant conditions co	entributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contri	ibute to the	cause of death?
ds	w requires that been signed I should be det	d b	Bilateral 106	er pnev	40419			1 🗆 Y	es 2 Ano	3 Probab	iy 4 🗆 Unknown
200	w require	lete	Acute +ul	ular u	er core:			24a. Was a	n 24h W	Vere autones	y findings available
Re	The law requires that the rate has been signed by the page 2 should be detache	Completed by	7, 60,00	70147 27	(0)(3			autops perforr	med? de	rior to compi eath?	iletion of cause of
tal		a	25. Was case referred to medical	4 - 10 7			26 Place of Dea	1 ☐ Yes : th (Check only on		Yes 2	∐ No
<u>&gt;</u>	ysici is cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ER/Outpatien	t 3 DOA Oth		ome 5 Reside		r (Specify)	
סו	g Physical dispersal di		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of		v at	28d. Describe ho			
jo	ath. r: Aft	atio	1 Action 5 Pending 2 Accident investigation		oar, injury		Yes 2□No				
Division of Vital Records,	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica complately filled in by the funeral director, the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (		eet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	r or Rural R	Route Number,
	pital urs a erei		29a. Certifier 1 Certifying Phy					<u> </u>			
	24 hc 24 hc Fun stely	edical	(Check only one)	vsician: To the best of r iner: On the basis of ex and manner stated	amination and/or in	vestigation, in my o	ne, date and place, pinion, death occur	red at the time, d	ause(s) and man ate and place, a	ner as state nd due to th	ed. ne cause(s)
	To the h within 2 To the f complet	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed	(Month, Da	y, Year)
	- 5 m 0		I asked ab -	nio		000	55 190		March		
	121		30. Name and address of person who c		h (Item 23a) (Type.						
_	101		Alfred A Pin			Hospita	1 106	Bou St	Elk	+09	MO
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's		0'	7				
	Registr	ar	MAR 2	3 2004	The state of the	ASSEASE.	AST TO THE PARTY OF THE PARTY O				

		7	For State Registrar	State of Ma	arylan	-	artment rtificate			ınd M		jiene	104	09165
	Physicia	_	Decedent's Name (First, Middle,     Doris Jane								2. Date of Dea Month March		∩ <sup>Year</sup>	3. Time of Death 5:30 A M
	/Medic Examin		4a. Facility Name (If not institution, 19938 Gore	give street and number)				Town, or	Location o	f Death	122 011	4c. Count	y of Death Ltimo	
Ī	Funeral Director					ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day May 10	, 1923	9. Birthp Cour Pen	olace (State or Foreign ntry) nsylvania
	yland		Usual Residence of Decedent  10a. State 10b. County			, Town or Lo							1	0d. Inside City Limits
	the Ma 28a-f s	Director	MD Balti	more	F'Y	eelar	10f. Zip	Code	-		1	l 0g. Citizen of	What Cour	1 □ Yes 2X No
	th with 23e or	E D	19938 Gore M	ill Road			2	2105	3			U.S.A		
336	72 hours after death with the Maryland "natural", or Itama 23a or 28a-f show olical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? d 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Am <i>eric</i> ack, White, fy: V	
21215-0036	c * 38	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)	5+)	(Give life.	dent's Usua kind of wor DO NOT us UPER	rk done d se retired	luring most )	of workii	ng	16b. Kind of E		
Maryland 2	s 1 and 2 should be filed within f Heaith and Mental Hygiene. Item 27 is marked other than other traumatic avant, the M	To Be Co	17. Father's Name (First, Middle, L Hubert C. Fe						18. Mothe		(First, Middle, 3. Tho		me)	
Mary	12 shou h and M 7 is mar traumat		19a. Informant's Name/Relationshi				-				Route Number			
Baltimore, I	00= 5		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Sp.	3 □Removal from State	20h P	lace of Dispo emetery, crei nt Sta emete	sition (Nam	ne of	I	, ,	ate h 10	20c. Location	- City or To	
Balti	permit. Peg Depertment important: any injury o		21. Signature of Funeral Service L	icensee		22	Name and	d Addres Har	tenst	]	Mortu New Fr	eedom	Inc. , PA 1	.7349
8766,	cate be executed by sicion end by sicion end by sicion end the burial-transit	dical Examiner	23a. Part1. Exter the disease, or o shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as  b. Due to (or as  c. Due to (or as	a consequence a consequence	uence of): Le uence of): Le uence of):	rejo esh	ca la per	De lei	de de	refa Epot i	derk	0	Approximate Interval Betweeh Onset and Death S Musual 20 905
.O. Box 68	death certifi e ettending   id for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent prégnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 ☐ Feta	I death 3	∃Ectopic pr ∃ Oth <i>e</i> r (sp						ate of delive	ery Day Year
<u>α</u>	requires sen sign hould be	eted by Ph	Part II. Other significant condition	s contributing to death t	out not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to 1 ☐ Y	es 2 No	3 Prob	ne cause of death?  pably 4 Unknown  psy findings available
l Rec	The ete h page	Compl				-					autop: perfor 1  Yes	sy	prior to condeath?	Moletion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatie	nt 3 DC	Othe	200		(Check only or	-07	her (Specif	iv)
Division of Vital Records,	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification; To	27. Natural 5 Pending investigation	28a. Date of Inju (Month, Da		28b. Time o Injury		8c. Injun Worl		No	28d. Describe h	ow injury occu	irred	
DIVIS	ei or Att s after de si Direct	Certific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 28e. Place of In building, e	jury - At ho tc. (Specif	ome, farm, st y)	reet, factory	/, office			28f. Location (S City or Tow		ber or Rura	al Route Number,
	ha Hospil n 24 hour he Funer pletely fills	edicai		Physician: To the best examiner: On the basis of and manners	of examina		vestigation	, in my o	oinion, deat		ed at the time, o	fate and place	, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Topla	er,	Mo	290	DI	9/5	5	4	3//8	ed (Month,	Day, Year)
	lo		MARKS.1	CAPUAN	death (Item	0	169Z	26	You	le	RD	MON	IZA	MJ 2441
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regist	ar s olgna	Caro A	C ASS		* .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

*		State Registrar  1. Decedent's Name (First, Middle, Last)			Certificate	e or Dear		Date of Dea	eg. No.		3. Time of Death
Physicia	an	MAYBEI	_	ARRIS	ON			Month 3	Day	8 Y	0230
/Medic Examin	2 1	4a. Facility Name (If not institution, give	street and number)			Town, or Location	/			unty of Death	
	N. S.		dal Medica	of Cent	hday) If Under	344/30		Data of Birth		com ic	
Funeral Director		5. Social Security Number  222-10-0936  Usual Residence of Decedent	7. Age	(In yrs. last birt	/rs. Months	Days Hour	s Min.	Date of Birth (Month, Day tober 2	Year) , 1923	Mary	place (State or Forei ntry) land
Mo M		10a. State 10b. County		10c. City, Towr	or Location						Od. Inside City Limit
right lied	to	Maryland Somerse	t			Crisfi	eld				1∑Yes 2□N
or 286	Director	10e. Street and Number			10f. Zip	Code			0g. Citizer	of What Cou	ntry?
23a		114 Maple Street				218]				USA	
lied within 72 nous are bean with the maryano tal Hygene tal Hygene dother than "natural", or items 23a or 28e-f show event, it a Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			ent of Hispanic offy Cuban, Mexi	Origin? (Specify can, Puerto Rica	Yes or No- an, etc.)		Race - Americ Black, White, ecity: While	etc.
natur	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a.	Decedent's Usua (Give kind of wor life. DO NOT us	I Occupation	nost of working		16b. Kind	of Business/In	dustry
19. 19. 19. 19. 19. 19. 19. 19. 19. 19.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	) 7	`life. DO NOT us Ctiviti∈				Munr	sing Ho	VMC
Hygier Hygier ther th	S	17. Father's Name (First, Middle, Last)		A	CLIVILIE		other's Name (F	irst Middle			Mic
e ta b	Be	George Sterling					achel To				
d 2 should th and Men 7 is marke traumatic	ဥ	19a. Informant's Name/Relationship (Ty	roe. Print)	19b.	Mailing Address					own, State, Zij	Code)
h a 7 is		Sharon R. Corbin (			4 Maple		- Crisf		NT 2		
E He He		20a. Method of Disposition		20b. Place of	Disposition (Name), crematory or o		Date			ion - City or T	own, State
00		1 X Burial 2 ☐ Cremation 3 ☐ F  * 4 ☐ Donation 5 ☐ Other (Specify)			de Memori		3/18/04	4	Crist	ield	Maryland
permit. Page Department of Importent: If any injury of once.		21. Signature of Funeral Service Licens Mary Beth Brad	Magrillu-	Print	22. Name an Bradsh	d Address of Fa	ns Fune:	ral Ho	me		and 21817
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of		he death. Do r	ot enter the mod	e of dying, such	as cardiac or re	spiratory are	est,	YI	Approximate Interval Between
	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, loading to infried acases. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Due to (or as a	consequence of	.fs	neum	unia				
± 00 00	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	Fetal death	3 □Ectopic pr 5 □ Other (sp			•	230	. Date of deliv	ery Day Year
uires that the de signed by the Id be detached	ρ	Part II. Other significant conditions co	ntributing to death but	not resulting in	the underlying c	ause given in Pa	art I.				he cause of death?
Attending Physicien: The law requires that the death cert redeath ar death ar death car death by the attendinector. After this certificate has been signed by the attendinector, page 2 should be detached for use by the funeral director, page 2 should be detached for use	Completed							24a. Was a autop perfor 1  Yes	med?		opsy findings availa impletion of cause of
icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hanning! —	CEE T			ace of Death C	heck onl o	ne		
Physic this co	ဥ	1 Yes 2 No	Hospital: 1 Inpatien				Nursing Home	5 🗌 Resid			fy)
ending Peath. or: After I	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year) I	njury M	!8c. Injury at Work? 1 ☐ Yes 2	! □ No				
Dia#t		4 Homicide determined	28e. Place of Injui building, etc.	(Specify)				City or Tow	n, State)		al Route Number,
To the Hospitel or Attending Physicien: The within 24 hours atter death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exam	rsician: To the best of iner: On the basis of and manner stat	examination an	d/or investigation	, in my opinion,	death occurred	at the time, o	date and pl	ace, and due t	o the cause(s)
To t To t	Σ	29b. Signature and title of certifier	-	D	A	c. License numb				igned (Month,	
		1			-	1005	7410 51		3/1	109	

			1 - For State Registrar	State of Marylar			of Health a of Death	and Mental	Hygier	201	0916
	St i et		1. Decedent's Name (First, Middle, Last)					2. Date of	of Death		3. Time of Death
1	Physici /Medio		BLANCHE PAULIN	E JEFFERS				MAR	CH 1	2 2004	7:00 A M
	Examir	er	4a. Fecility Name (If not institution, give s 23525 MT. EPHR.			DICK	wn, or Location o			4c. County of Dea	
	Funeral Director		210-24-3024	7. Age (In yrs. 74	last birthday) Yrs.	If Under 1 \ Months D	ear If Under 2		of Birth n, Day, Ye, 26	1'929 9. Bi	rthpiace (State or Foreign ountry) MD
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD MONTGOM		ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	a with the	Il Director	10e. Street and Number 23525 MT. EPHR.	AIM ROAD		10f. Zip Co			10g.	Citizen of What C	ountry?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f show other treumetic event, the Madical Examir et must be notified at	by Funeral (	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces?/ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Deceden f Yes, specify	Cuban, Mexican	gin? (Specify Yes o , Puerto Rican, etc	r No-	14. Race - Am Black, Whi Specify: WH	te, etc.
21215-0	within 72 ho jiene. r then "natur the Medicell	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual D kind of work of DO NOT use r DR IV	lone during most etired)	of working	Mo	Kind of Business ONTGOME UBLIC S	RY CO.
Maryland ?	ild be filed lental Hygie ked other ic event, II	To Be C	17. Father's Name (First, Middle, Last) WALTER STONE P	OOLE	•			r's Name (First, Mi EL REBE(		,	ORD
	and 2 should balth and Men n 27 Is marke ler treumetic	_	19a. Informant's Name/Relationship (Ty) ELEANOR WILKINS	•				r or Rural Route N			
altimore,			20a. Met/fod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Disposemetery, crem	natory`or othe	r place)	Date 3/16/04		Location - City or	Town, State
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service License		22 H	. Name and A	ddress of Facility	AL HOME			
	Pnysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the deat te cause on each line.			dying, such as		ry arrest,	•	20838 Approximate Interval Between Onset and Death
8760,	Medical Examiner bhysician and the burial-transit	dicai Examiner	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a) (or	uence ot):	he	art o	disea	se		
.O. Box 6	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3□	Ectopic pregn Other (specif			_	23d. Date of de Month	livery Day Year
٥.	luires that n signed by		Part II. Other significant conditions con	tributing to death but not res	ulting in the un	nderlying caus	e given in Part I.			10	the cause of death?
al Records,		e Completed	25. Was case referred to medical				00.00	1	Was an utopsy performed 1	prior to death?	utopsy findings available completion of cause of
Vita	ysicien: is certific director,	ОВ	examiner?	ospital: 1   Inpatient 2	ER/Outnation	3 DOA	Othor	of Death (Check o	,	6 □Other (Sne	cife)
Division of	ding Ph .r After th funeral	-	27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	28d. Descr		jury occurred	City)
Divis	To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, of	fice	28f. Locati City of	on (Street : Town, Sta	and Number or Ri ite)	ural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dirr completely filled in I	edical (	29a. Certifier 1⊠ Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the	ne time, date and my opinion, death	place, and due to h occurred at the ti	the cause me, date a	(s) and manner as nd place, and due	s stated. to the cause(s)
	To the within :	Ž	29b. Signature and title of certifier	wolf		29c. Li	D33/	29	29d. C	Pate signed (Mont	h. Day, Year)
	30		30. Name and address of person who co	popleted cause of death (Item	D (Type, E	7820-	Phys	icians	LN.	# 241	Erkelle
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 3 2004	2. Registrar's Signa	Anac	No 3				7	Med 2085

			1- For State of Maryland / Depart Registrer Certif		ental Hygiei	
ĺ	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last)  Marie C. Lockwood  4a. Facility Name (If not institution, give street and number)  Union Hospital	b. City, Town, or Location of Death E1kton	March 1	Day Year 3. Time of Death 3. 2004 1:46a M 4c. County of Death Cecil
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Ye April 26	
	death with the Maryland ims 23a or 28e-f show frount be notified at	Director	10a. State         10b. County         10c. City, Town or Locat           MD         Cecil         Cecilton		100	10d. Inside City Limits 10€ Yes 2 □ No Citizen of What Country?
336	be filed within 72 hours after death with the Marylan ital Hygiene. by other than "netural", or items 23a or 28e-f show event. The Medical Examinar must be notified at	by Funeral Dir	172 Center St. Apt. 6A  11. Marital Status	21913 s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto I	U.	S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	filed within 72 hours after Hygiene. Ither then "netural", or ite ont. The Medical Examina	Completed	1 2 College (1-4or 5+)	t's Usual Occupation d of work done during most of workir NOT use retired) memaker	C	Kind of Business/Industry
Maryland	s 1 and 2 should be fil if Health and Mental H item 27 is marked ott other traumatic even	To Be	The state of the s	18. Mother's Name Dollie Address (Street and Number or Rura		,
Baltimore, N	Pages 1 and nent of Health int: If item 27 ary or other tr		Earl S. Lockwood (husband) P.O  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify) Zion Cem	on (Name of Dory or other place)	ate 20c.	MD. 21913 Location - City or Town, State
■ Balt	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee M00510 23 M 1 23a. htt. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	o west cross	Home of St. Gale	Stephen L Schaecena, MD. 21635  Approximate Interval Bathween
68760	Physician and bhysicien and bhysicien and bhysicien and stree bruial-transit	dical Examiner	Immediate Caus. (Final disease or continon resulting in death)  Sequentially list conditions, acause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	CARDIAL IN		Onset and Death
.O. Box 6	ath certif titending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ec 4 □ Pregnant at time of death 5 □ Or 9 □ Unknown	etopic pregnancy ther (specify)		23d. Date of delivery Month Day Year
٥.	w requires that the de been signed by the a should be detached f	þ	ACUTE RENT FAILURE	* -		o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
tal Rec		Be Completed	HYPERTENSION  25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed 1 Yes 2	
Division of Vital Records,	ttending death. ctor: Afte / the fune	Certification; To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Hospital: 2 ER/Outpatient  28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28b. Place of Injury · At home, farm, street, building, etc. (Specify)	3 DOA Other: 4 Nursing Hon 28c. Injury at Work? M 1 Yes 2 No	ne 5 Residence 8d. Describe how in	njury occurred  and Number or Rural Route Number,
	To the Hospitakor Attenn within 24 hours after death To the Funerei Director: completely filled in by the	edical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, death or 2  Medicel Exeminer: On the basis of examination and/or investigated.	ocurred at the time, date and place, a tigation, in my opinion, death occurre	nd due to the cause ad at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	Tot Tot comp	Σ	29b. Signature and title of certifier  Mushul M. Manyus M.  30. Name and address of paragraphy the completed course of death (New 23a) Tuno Rich	29c. License number  D 57662		Date signed (Month, Day, Year)  3/13/2-004  WILMINGTON
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print MISAEL M. MANDUEZ, M. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	DE.	19801	WILMINGTON
	riogisti	-GII	MAR 2 3 200 ₹	The state of the s		

		•	For State Registrar	State o	f Marylan		irtment <i>tificate</i>			and M		giene Reg. No. 2	004	0916	9
			1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	ith Day	Year	3. Time of Death	
	Physicia /Medic	al .	Mary Mothers	0							March	11	2004	7:30 P	М
· ·	Examin	er	4e. Fecility Name (If not institution, give s		mber)		4b. City, T						nty of Death		
			Vindobona Nursing I		7 4 - //		Bradd If Under 1		Hei If Under:	ghts	8. Date of Birt		Freder		
	Funeral	Ì	5. Social Security Number 6. Sex 216 - 44 - 3560	M 2∰F	7. Age (In yrs. I	03 Yrs.		Days	Hours	Min.	July 6	v. Year)	Cou	place (State or Foreigntry) Marylane	gn d
	Director	-	Usual Residence of Decedent		π.	03					July 0	, 1700	<u> </u>	naryran	
	yland		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limit	
	a-fsl	ctor	Maryland Frederic	k	J	effers	on							1 □ Yes 2 ☑ N	10
	in th	Directo	10e. Street and Number				10f. Zip (	Code				10g. Citizen	of What Cou	intry?	
	afh w	ra l	1606 Gapland Road					755	. 0 :				.S.A.	and tadion	
36	be filed within 72 hours after death with the Maryland at Hygiene.  de Hygiene.  de other then "natural" or items 23s or 28s-f show event, it o Medical Examinar must be notified at event.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Nover Married 4 Divorced	Armed Fo	2 Nanot		was Decede f Yes, speci l □ Yes 2		panic Orig , Mexican Specify:	gin ( (Spe i, Puerto	ecify Yes or No- Rican, etc.)		Black, White		
5-0036	2 hou	ed	15. Decedent's Edu	cation	avalla	16a. Deced	ient's Usual	Occupat	ion			16b. Kind o	f Business/Ir	ndustry	
2L2	nin 72 ". "na "na Medili	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (	1-4or 5+)	(Give	kind of work DO NOT use	retired)	iring mosi	t of work!	ng				
2121	filed within 72 Hygiene. other then "nef	Completed	Eldilonally, 3000 loarly (0 12)		4	N	urse					Feder	al Gov	rernment	
9	al Hy al Hy fother	Be (	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Meiden Sun	name)		
yla	2 should be and Menfal Is marked o	2	Hamilton W. Shafer								S. Arn				
	2 shi and Is m		19a. Informant's Name/Relationship (Ty				•				I Route Numbe				
	1 and 2 Health em 27 ther tru		Jerome W. Offutt/E	xecuto		lace of Dispo			d Sti		)ate	20c. Location		and, 21701 own. State	_
وّ	Pages nenf of P nnt: If It ury or o		1 Burial 2 ☐ Cremation 3 ☐ R	emoval from	State	emetery, crer Mary	natory or oth	her place		73/15	5/2004			e, Marylan	n d
altimore,	arfme arfme ortant		* 4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	98	01		. Name and				7/2004			Church Stre	
Ba	permit. Pages 1 and 2 should b Departiment of Health and Menti Important: If Item 27 is marked any injury or other traumatic e once.		P. Ryan M	E Mas	lian	Ke	eney at	nd Bas	ford	P.A.		Home Fr		k, MD, 21701	
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on o	caused the death each line.				AILU			rest,		Approximate interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to	(or as a conseq										
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):									
)	afe be execufed hysician and fhe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a conseq	uence of):									
60,	ician burial	cai E			(0. 40 4 00.1004	201100 017.									
687	phys phys s fhe	edic		d											
Box (	eath certific attending p for use as f	J/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		7					23d.	Date of deliv	very	
o.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		pirth 2 ☐ Feta nant at time of d lown		Ectopic pre Other (spe						Month	Day Year	
Records, P.	uires fhat fhe de n signed by fhe a Id be defached f	b	Part II. Other significant conditions con	ntributing to d	leath but not res	ulting in the u	nderlying ca	iuse givei	n in Part I			obacco use d		the cause of death? bably 4 □Unknov	
CO	w requires to the second secon	lete									24a. Was		b. Were aut	opsy findings availat	ble
	The lavafe has	Completed									autor perfo	rmed? 2X No	death?	ompletion of cause of 2□ No	71
ita		Be C	25. Was case referred to medical						26. Place	of Deatl	(Check only o				
<u>&gt;</u>	Physician: r this certifica iral director, p	To	examiner? 1 ☐ Yes 2 No	lospital:	Inpatient 2	ER/Outpatier			41 NU	ırsing Ho	me 5 ☐ Resid	dence 6 🗀	Other (Spec	ify)	
o uo	Attending Pt at death.  ector: After #by the funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date (Mor	of Injury oth, Day Yeer)	28b. Time o Injury	f 28	3c. Injury Work¹ 1 □ Y	at ? es 2□		28d. Describe I	now injury oc	curred		
Division of Vital	or Attendation of a fier death of the fier by the field in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		e of Injury - At he ling, etc. (Specif		reet, factory,	, office			28f. Location ( City or Tox	Street and Ni vn, State)	umber or Rui	ral Route Number,	
	To the Hospital or Attending Physician: within 24 hours affer death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier to Certifying Phy (Check only one)	ner: On the i											
	To the within To the	Me	29b. Signature and title of certifier	Illa	2150 P	in)	29c.	. License		667		29d. Date si		2, 2004	-
0.0	5		30. Name and address of person who co	ompleted cal		n 23a) (Type,	Print)	142.0				) 21		-(	
	Sta	ate	31. Date filed (Month, Day, Year)		Registrar's Signa	ature	Br	, N	1001	UK,	. ((	, - (			
	Regist	rar	MAR 2	3 3 200	L. C. C. C.	Welley She	X	34	A						

State of Maryland / Department of Health and Mental Hygiene 2 🕕 🖺 👢 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** MARCH JOSEPH LOUIS MURPHY, SR. 13.2004 9:26A /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LAPLATA
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | MAY | 17,1921 CHARLES

9. Birthplece (State or Foreign CIVISTA MEDICAL CENTER 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Euneral** MARYLAND 1<del>∏</del>M 2□F 82 Director 216-16-0320 S Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director FAULKNER MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20632 U.S.A. 9475 MURELL LANE Q/ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 22 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 5-0036 1 Yes 2 No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FARMER FARMING Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 9 and Mental MARY MAGDALENE BRIDGETT BENJAMIN WINFIELD MURPHY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Dispertment of Health a Important: If Item 27 is any injury or other trai Ш 5675 RIVER ROAD BRYANS ROAD, MD. 20616 T.ELAINE HERBERT-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ▼Burial 2 □ Cremation 3 □ Removal from State ST.PETER'S CEMETERY 3-17-04 WALDORF, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Funeral Service Licensee PAYMOND FUNERAL SERVICE, P. A.

1.A PLATA, MARYLAND 20646

23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause — each line. 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ZWO arcinomo **Physician** 00 resulting in death) /Medical Due to (or as a consequence of): **Examiner** NO 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Examine burial-transit 0 EVERYH certificate be execu Due to (pras a consequence of) Box 68760, attending physicien Physician/Medical the as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ② No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 3 Probably 42 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No. Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1@Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide efter To the Hospitel within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3-13-04 D-46046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. MIRZA ALIKHANI, MD P.O. BOX1890 LAPLATA, MD 20646 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 3 2004 DHMH 17 HeV 1/2001

**ORIGINAL** 

	1- St	or tate egistrar AMF	ND ITEM				ind / Depa 9 3/2 <b>2/€</b>				and M		Reg. No	200	) 4	09171
Physician	1. Dec	edent's Name Arthur	(First, Midd	e, Last) mas	Mille							2. Date of De Month Feb. 2	Da	y Y	'ear	3. Time of Death 3;05pm M
/Medical Examiner	G	cility Name (li arrett	Co. M	lem. I	Hospit	al	s. last birthday)	,	land	Location o		8. Date of Bir	G	. County of	t	ace (State or Foreign
Funeral Director	23	ial Security N 5 40 2 Residence of	608	6. Sex 1 🔯 №	1 2□F	7. Age ( <i>m yr</i>	Yrs.	Months	Days	Hours	Min.	June !	19	27	Count	(ry)
death with the Maryland me 23a or 28a-f show r must be rotified at	10a. S	itate MD	10b. County Garr				city, Town or L Oakland	ocation		7=						od. Inside City Limits  1 ☐ Yes 2 ☐ No
th with the Mar 23a or 28a-f el 181 be motified	10e. S	treet and Nur 1498 G		Rd.					2155					usa USA		
		arital Status  Never Marri  Widowed	_	ried	Armed For	2 No		Was Deced If Yes, spec 1  Yes		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	D-	14. Race - Black, SpecifyW	White, e	etc.
21215-0036 ed within 72 hours att yglene. in than "netural", or it, the Madical Exam Completed by F	Eler	(Spec	15. Deceder ify only higher ndary (0-12)	nt's Educa est grade d	tion completed) College (1	-4or 5+)	(Give	dent's Usua kind of wo DO NOT us	rk done d se retired,	ation during most	t of worki	ng		and of Busi		
Maryland 2 ad 2 should be filled v th and Mental Hygie th marked other treumatic event, tt	17. Fa	ther's Name			•			~ 234.11				(First, Middle	, Maider			
Mary and 2 shou salth and M 27 le mar er treumat	19a. i	nformant's N Elsie	ame/Relation Miller	ship <i>(Type</i>		,	149	8 Gar	rett	and Numbe	or or Rura Oak	I Route Numb	er, City	1550		
Baltimore, Mispermit. Pages 1 and 2 Department of Health & Important: If them 27 is more any injury or other trepage.	1	Method of Disposition 12	☐Cremation 5 ☐Other (-	Specify)		State	Place of Disp cemetery, cre Rocky G	ap Ve	ther plac tera	ns ¢e	FEB :	27,2004 erv		ocation - C berla		
Ball permit. Depart Import eny In		ignature of A	Md A		end	ock	eath. Do not en		A. hurc	Burdo h St.	ck F Ki	H tzmill		MD 2	1538	Approximate
8760, sate be exacuted why sician and the burial-transit the burial-tr	Seque if any cause Cause that if result	shock, or headiate Cause is or condition in death) entially list co., leading to in a Enter Unde in Usease or initiated eventting in death)	(Final on	a. b. c. d.	Due to	or as a cons	sequence of):	J in	Fere	مند						Onset and Death
The law requires that the death certificet the has been signed by the attending phypage 2 should be detached for use as the control of the beautiful to the physical factorization.	IF FE 23b.	MALE: Was deceder in the past 12 1 Yes 2 9	months? ☐ No	230	1 Live b	come of pre irth 2 F eant at time o	etal death 3	⊒Ectopic pi □ Other (sp						23d. Date Monti		ry Day Year
Cords, P. wrequires that baan signed b should ba deta		. Other signi	ficant conditions type by p				resulting in the	underlying o	ause give	en in Part I						e cause of death? ably 4 IIII nknown
			hyp	ese	swi							24a. Was auto perf 1 \( \triangle Yes	opsy ormed?	_/ de	ere autor or to con ath? Yes	osy findings available npletion of cause of 2 No
of Vital F Physicien: Th this certificate rai diractor, pag	25. V	/as case refe xaminer?		_	spital:		7500		Oth			Check only		2 DO11	10	A
🛬 출 뿔을 🗜	27. N	Yes 2 X		- '	10	Inpatient 2 of Injury th, Day Year	2 ER/Outpatie		28c. Injun World	40140	-	me 5 ☐ Res 28d. Describe				7
Division of the or Attending P rs after death. Tall Director: After to a line to the tunera	1 2 3	☐ Natural ☐ Accident ☐ Suicide ☐ Homicide	6 □ Coule	tigation	28e. Place		at home, farm, s	М	1 🗆	x≀ Yes 2□		28f. Location City or To	(Street a	nd Number 'e)	or Rura.	l Route Number,
		Certifier (Check only one)	1 Certify 2 Medica	ing Physi Il Examine	r: On the b	best of my asis of exam ner stated.	knowledge, dea nination and/or i	th occurred	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the	cause(s	s) and man	ner as st ad due to	ated. the cause(s)
	296.	Signature and	title of certif	ier a p	, 14c	J. J.	MO			e number	50.3	1	29d. Da	ate signed		
3 NA	04.5	Patric	ia B.	Gots	ch		1tem 23a) (Type		aklaı	nd, M	D 2	1550				
State Registra	=	ate filed (Mo	FEB 2		104	Supplied S		Arank								

	-	For L_State	State of Maryland / De	epartment of Health Certificate of Deatl	and Mental H	ygiene 200	4 09172
G#4.0		Registrar		Jenilicate of Death	2. Date of [	rieg. No.	3. Time of Death
Physicia	6	1. Decedent's Name (First, Middle, Last)			Month	11, 2004 Yes	
/Medic	al	KATHERINE	FRANCES	PHOEBUS  4b. City, Town, or Location		4c. County of D	
Examin	er	4a. Facility Name (If not institution, give str			TOT Double		
		Greater Baltimore   6. Sex	Medical Center  7. Age (In yrs. last birth)	Towson  day) If Under 1 Year   If Under	er 24 Hrs. 8. Date of E	Baltimo	re Birthplace (State or Foreign Country)
Funeral			M <b>¾</b> □F 89 Yr	Months Davs Hours	Min. (Month, I		Maryland
Director	1	Usual Residence of Decedent					
/land	Ì	10a. State 10b. County	10c. City, Town				10d. Inside City Limits
Man,	ţō	MD. Harfo	rd	Jarre	ttsville		1 ☐ Yes 2 No
r 28s	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What	
h witi		4040 Old Fede	ral Hill Road				States
72 hours after death with the Maryland natural; or Items 23s or 28s-f show iteal Examenation must be multified at	Funeral	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	origin? (Specify Yes or I an, Puerto Rican, etc.)	No- 14. Race - A Black, V	merican Indian, /hite, etc.
or it		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes 🙀 No Specif	y:	Specify:	White
ural',	d by	3X Widowed 4 □ Divorced	Year or Dates:	Decedent's Usual Occupation		16b. Kind of Busine	
"natural"	Completed	15. Decedent's Educa (Specify only highest grade	completed) (	Give kind of work done during mi life. DO NOT use retired)	ost of working	100111111111111111111111111111111111111	,
withir ene. then	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Clerk		Bank	ing
filed within Hygiene. other then "		17. Father's Name (First, Middle, Last)			her's Name (First, Midd	dle, Maiden Sumame)	
d be ental	o Be	Walter H	Goodwi	.n K	atherine	В.	Dorsey
2 should be filed withing and Mental Hygiene. Is marked other there sumatic event, the Mental Hygiene.	ပ္	19a. Informant's Name/Relationship (Typ		Mailing Address (Street and Num	ber or Rural Route Nur	nber, City or Town, Sta	te, Zip Code) Md.
and a share of the state of the		Donald M. Phoebu	is/Son 404	Old Federa	l Hill Re	d. Jarr	ettsville,
s 1 a f Hear item other		20a. Method of Disposition	cemetery	Disposition (Name of crematory or other place)	Date	20c. Location - City	or Town, State
Pages nent of h int: If ite		1 X Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State Morela	ind Mem.Park	3/15/2004	4 Parkvil	le, Md.
그 문원 중 .	1	21. Signature of Funeral Service Ucertse		22. Name and Address of Fac		tsville,	
Demi Depa Impo		11. Lydday	n Nurs	E.G. Kurtz	& Son Fu	neral Hom	e. P.A.
- 1 L 4		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do no	ot enter the mode of dying, such a	as cardiac or respiratory	y arrest,	Approximate Interval Between Onset and Death
Pnysician	y.	Immediate Cause (Final disease or condition	1/2	nonia			Daays
/Medical		resulting in death)	Due to (or is a onsequence o	f):			
Examiner		Sequentially list conditions b.					
p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury	Due to (or as a consequence o	f):			
ecute and trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence o	f):			
OX OO ( OU) certificate be executed tring physician and use as the burial-transit		Togathing in doubtry sales	Due to (or as a consequence o	1).			
cate the character the	dicai	d.					
OX O	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregnancy			23d. Date of	delivery
death of attention and for us	ian	in the past 12 months?	1 Live birth 2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
the d	ysic	1 ☐ Yes 2 € No. 9 ☐ Unknown	9☐ Unknown	, , , , , , , , , , , , , , , , , , , ,			
7. # 5. #							
de de	ā	Part II. Dther significant conditions con-	tributing to death but not resulting in	the underlying cause given in Pa	rt I. 23e. D	id tobacco use contribu	te to the cause of death?
uires th uires th signed	þ	Part II. Dther significant conditions con	tributing to death but not resulting in	the underlying cause given in Pa			te to the cause of death?
GOLDS, P.O. BOX or wrequires that the death certifics been signed by the attending pt should be detached for use as I	þ	Part II. Dther significant conditions con	tributing to death but not resulting in	the underlying cause given in Pa	1 24a. W	☐ Yes 2☐ No 3☐	Probably 4 Unknown
28 8	þ	Part II. Dther significant conditions con	tributing to death but not resulting in	the underlying cause given in Pa	24a. W	As an utopsy priormed?	Probably 4 Unknown e autopsy findings available to completion of cause of th?
The lay ate has page 2	Completed by		tributing to death but not resulting in		24a. W	Yes 2 No 3 (  As an antopsy enformed? s 2 No 1	Probably 4 Unknown e autopsy findings available to completion of cause of
VICAL KE sician: The la scertificate has lirector, page 2	o Be Completed by	25. Was case referred to medical	tributing to death but not resulting in	26. Pla	24a. W au pe 1 □ Ye	Yes 2 No 3 (  As an attopsy prior deal s 2 No 1     to one	Probably 4 Unknown e autopsy findings available t to completion of cause of h? Yes 2 No
OT VITAL KEO Physician: The laver this certificate has eral director, page 2	To Be Completed by	25. Was case referred to medical examiner?  1 □ Yes No H  27. Manner of Death	ospital: 2 EF/Out	26. Platient 3 DOA Other 4 D	24a. W at pt 1   Y at pt 2   Y	Yes 2 No 3 (  As an attopsy prior deal s 2 No 1     to one	Probably 4 Unknown e autopsy findings available t to completion of cause of h? Yes 2 No
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Certification: To Be Completed by	25. Was case referred to medical examiner?  1   Yes   No	28a. Date of Injury (Month, Day Year)  28b. T In  28b. T In  28c. Place of Injury · At home, far building, etc. (Specify)  sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	26. Plantient 3 □ DOA Other: 4 □ Ime of plury at Work? M 1 □ Yes 2 m, street, factory, office death occurred at the time, date d/or investigation, in my opinion, of 29c. License number 1.	24a. Wate accepted ac	As an utopsy 2 No 3 of the san utopsy 2 of the san utopsy 3 of the san utopsy 3 of the san utopsy 4 of the san utopsy 5 of the	Probably 4 □Unknown  e autopsy findings available to completion of cause of thy Yes 2 □ No  Specify)  or Rural Route Number,  er as stated, due to the cause(s)

			For State Registrar		State o	f Marylan			t of H				gienez Reg. No.	004	09173
	£ Physicia	an	Decedent's Name									2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Clista		Jean		attersor					03	13	04	0230 M
	Examin	er	4a. Facility Name (If	1 11 -	1 / 1	spita	1		2	erla	- 1			unty of Death	
	F		5. Social Security Nu	~	Sex HC	7. Age (In yrs.		_		If Under		8. Date of Bi		llegar	place (State or Foreign
п	Funeral Dirœctor		234-58-56		1 □ M 2 💢 F	69	Yrs.	Months	Days	Hours	Min.	B. Date of Bi (Month D Jan 26	1935	Cau	WV
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	72 hours after death with the Maryland natural', or Items 23a or 28a-1 ehow Iteal Exact. at trust to cotified at	ō	MD State	Allega	ny	10c. Cit	y, Town or Lo Cumb		d						10d. Inside City Limits  Y☐ Yes 2☐ No
	the N	Completed by Funeral Director	10e. Street and Num	ber				10f. Zip	Code				10g. Citizer	n of What Cou	ntry?
	3a or	<u>=</u>	923 Ridge	edale Av	enue					1502		1		JSA	,
	deatl	ner	11. Marital Status		Armed Fo	edent Ever in U	.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)	0- 14.	Race - Ameri	
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pu	be filed tal Hygi d other event, t	Bec	17. Father's Name (F									e (First, Middle			
Maryland	Men Men arke	To		A. Patte			40h Maill	644	(0)			inia (St	•		
Ma	nd 2 shi alth and 27 Is m ir traum		David Pat	tterson	bro	other	Rt. 4	Box 2	225	ina ivumbe	r or Hun	Salen	ner, city or r	Wn, State, Zij	<sup>7</sup> 26426
Jre,	of Heal of Heal fitem 2 r other		20a. Method of Dispo				Place of Dispo cemetery, crea	matory or o	ther place	a)	Ţ	Date	20c. Local	ion - City or T	own, State
<b>Baltimore</b> ,	Pag nent nt: I		* 4 □ Donation	5 Other (Spec	The state of the s	Gree	enlawn I					3/17/2004	Clark	sburg	WV
Bal	permit. Departm Importe eny inju		21. Signature of Fun	MUD -	ensee ) . \ L	u'	2:					me, PA Cumber	dand M	D 21502	
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	Physician		Immediate Cause (F	inat	/ / /	0			1.	~					Onset and Death
ı	/Medical		resulting in death)	- 6	Due to	(or as a conseq	uence of):	and t	-	2					7 1 000
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	pe tis	inei	Sequentially list con if any, leading to impose cause. Enter Under Cause (Disease or in	nediate lying	Due to	or as a conseq	uence or):	ce	ul	Ca	em	tu	un	T	
	and and	Examiner	that initiated events resulting in death) Li		c	or as a conseq	uence of):								
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Box	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent			come of pregna		Testania es					23d	. Date of deliv	егу
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ls,	The law requires that the tie has been signed by thoage 2 should be detache	by	Part II. Other signific	cant conditions	contributing to a	eath but not res	ulting in the u	inderlying c	ause give	en in Part I.			tobacco use Yes 2□1		he cause of death?
orc	w requir been si should l	etec										-			
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Vital			25. Was case referre	ed to mertical						00.81		1 ☐ Yes	2 200	1 🗆 Yes	2 No
>		o Be	examiner?		Hospitat:	npatient 2	ER/Outpatie	nt 3 DC	Othe	A.C.		n <i>(Check only</i> me 5∐Res	200	Other (Specie	60
J Of	ding Phys h. After this funeral di	T:U	27. Manner of Death		28a. Date		28b. Time o		8c. Injury Work	at	-	28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Sion	D ta si	atic	1 ☑ Naturat 2 ☐ Accident	5 Pending investigat	ion	,,	,,	М		res 2 □ I	No				
Division	or Attendatter deatl Director: in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	280. Place	of tnjury · At he ng, etc. (Specif	ome, farm, st	reet, factory	, office				(Street and N wn, State)	lumber or Rur	al Route Number,
	spitel o	al Ce	29a. Certifier	1 Certifying	Physician: To the	best of my kno	owledge, deat	h occurred	at the tim	e date an	d place	and due to the	cause(s) an	d manner as s	tated
	To the Hospitel or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical	(Check only one)	2 ☐ Medical Ex	aminer: On the b	asis of examina ner stated.	ition and/or in	vestigation	, in my op	pinion, dea	th occurr	ed at the time.	, date and pla	ace, and due t	o the cause(s)
	To t To t	Σ	29b. Signature	itle of certifier	£			290	. License	number	_		29d. Date s	igned (Month,	Day, Year)
	. 0		20 Nome and add	12	Tu		220) 7	Die	00	01	13	7	_ 3	//3/	104
	10		Dr. A. B	Flaces	completed caus	se of death (Item	n 23a) (Type,	Print)	C	lina	201	land	MA	1 214	507
	Sta		31. Date filed (Month	Day, Year)	32. F	egistrar's Signa	ature		1	1				and the	
	Registr			MAR	2 3 2004	Blesse	s St	Ago	a Change						
DH	IMH 17 Rev 1/2	001				F									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM #8 PER 18 OF Mary 2004 Department of Health and Mental Hygiene 2001 09174 State Registrar 02/23/04, B.A.G.Kent Co. Certificate of Death Amended #8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Wesley L. Russum February 15, 2004 10:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Manor Chestertown der 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | 11-1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 ☐ F 218-16-8509 Director 81 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 TYes 2 No Funeral Director Kent Chestertown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 402 Morgnec Village Apt. 4D 21620 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 TYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 Yes 2 No ģ 3 Widowed 4 Divorced White natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 7th <u>Maintenance</u> <u>Gillespi Concrete</u> 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fith Department of Health and Mental Hy Important: If Item 27 Ie marked oth any injury or other treumatic even 18. Mother's Name (First, Middle, Maiden Surname) Be Layton Russum Mamie Holden Russum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Wiltbank 23232 Buck Neck Road, Chestertown, Maryland 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2/20/2004 MD Veterans Cemetery Hurlock, Maryland 21. Signature of Funeral Service L 2. Name and Address of Facility ellows, Helfenbein & Newnam Funeral Home, P.A. 30 Speer Road Chestertown, Maryland 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** anu /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2₺No 3□ Probably 4 □Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No death filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/2001

To the I

31. Date filed (Month, Day, Year) 8 2004

29b. Signature and title of certifier

1161. Ulum

KIN K. WUN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registar's Signature

415

Washington Ave., Chestestown, MD 21620

D21313

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Maryland		artment rtificate			nd M		iene 19. No.	200	4 09175
	Physici		1. Decedent's Name (First, Middle, Last)	Shanholt	14.1	~				2. Date of Deat Month	h Day	Yeer	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s Caton Manor Faci	treet and number) b lity	)	1	ltin	ore				ounty of Dee	
	Funeral Director		5. Social Security Number  232-10-5198  Usual Residence of Decedent		ast birthday) Yrs.	If Under 1 Months	Days	Hours	Min.	8. Date of Birth Month, Day 5/2//1	913	9. Bir W	thplace (State or Foreign ountry)
	hours after deeth with the Maryland turel', or items 23a or 28a-f show al Examiner must be notified at	Director	10a. State         10b. County           MD         Anarund           10e. Street and Number		, Town or Lo	Loum 10f. Zip C	ode 1090	)		t		en of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No ountry?
030	be filed within 72 hours after deeth with the Marylan tall Hygiene. Ital Hygiene. other than "naturel", or items 23a or 28a-f show other than "naturel", or items 23a or 28a-f show event. Ita Medical Examiner must be notified at	by Funerai	6851 B & A Blvd  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1			nt of His y Cuban	spanic Orig	in? (Spe Puerto f	cify Yes or No- Rican, etc.)	14	4. Race - Ami Black, Whi Specify: Wh	te, etc.
- - - -	filed within 72 ho Hygiene. other than "natur ent, the Wedical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		(Give life.	dent's Usual kind of work DO NOT use Labore	done di retired) T	uring most		(First, Middle, i	Ra:	ilroad	
Maryland 2	should and Men marke umatic	To Be	17. Father's Name (First, Middle, Last)  Jacob Shanholtzer  19a. Informant's Name/Relationship (Ty,		19b. Maili	ng Address (		Nanı	nie	Day  Route Number			Zip Code)
ore, m	Pages 1 and 2 nent of Health a int: If item 27 is iry or other tra		20a. Method of Disposition  1 X Burial 2 Cremation 3 P	emoval from State	lace of Dispo emetery, cre	1 B & sition (Name matory or oth	of erplace	)	D		20c. Loc	ation - City or	r Town, State
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 eny injury or other QDC8-		21. Synah re of Funeral Service Licens	Plan	2	hapel <sup>2.</sup> McKee P.O. B	Addres	of Facility	Hom			ints, 4	wv
ě			23a. Part1. Inter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	n. Do not en			, such as o	ardiac o				Approximate Interval Between Onset and Death
(-the/	And the price of t	dical Examiner	Sequentially list conditions. If any, teaching to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence to or as a conseq	uanse of):		0						
O. Box 68	ath certification (tending)	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3[	⊒Ectopic pre ⊒ Other (spe					23	3d. Date of de Month	blivery Day Year
ords, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	underlying ca	use give	n in Part I.		1 🗆 Y	es 2□	]No 3 □ P	to the cause of death?  Probably 4 Munknown
Division of Vital Records,	siclan: The law certificate has b rector, page 2 s	e Completed	25. Was case referred to medical	is method	<u> </u>			OS Place	of Dooth	24a. Was a autops perform 1 Yes	med? 2 StNo	prior to death?	utopsy findings available completion of cause of s 2 No
<u> </u>	ysicla is cert direct	To B	examiner?	lospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Othe	r		ne 5 Resid		Other (Sp.	ecity)
sion o	ending Physeath. or: After this he funeral dis	Certification: 7	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28	c. Injury Work 1 🗆 \	at ? ∕es 2 □ N	No	28d. Describe h			
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	n 24 ho n 24 ho he Fund bletely f	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.									
)	To the complex	Σ	29b. Signature and title of certifier,	reguo		29c.	License ) -4	0521		2	19d. Date	signed (Mon	nth, Day, Year)
	$\mathcal{D}$		30. Name and address of person who co		п 23а) (Турв	, Print) 3	350	R-M	iken	of Aren	e 18	229	2.5
3	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	· · · · · · · · · · · · · · · · · · ·		el :					

			Registrar	State of Marylan	d / Dep <i>Ce</i>	artment rtificate	of Hea	alth and Meath		ene 2 0	04	09176
•	Physicia Medic Examin	ai	4a. Facility Name (If not institution, give str					cation of Death	2. Date of Death Month March 13	Day 2004 4c. County	of Death	3. Time of Death
	Funeral Director		Upper Chesapeake  5. Social Security Number  213-44-8985  Usual Residence of Decedent	Medical Cent. 7. Age (In yrs.) 56		Bel A	Year If	Under 24 Hrs. Hours Min.	8. Date of Birth June 3,	Harf 1947		place (State or Foreign Land
5:00	with the Maryland a or 28a-f show	rector	10a. State 10b. County 10b. County 10c. Street and Number		y, Town or L urchvi		ode		10	g. Citizen of V		0d. Inside City Limits 1 ☐ Yes 2 No  ntry?
/ <i>OY</i> 5-0036	ler death Items 23 ner musi	d by Funeral Director	2617 Palmyra Driv  11. Marital Status  1  Never Married 2 Married  32 Widowed 4 Divorced	E. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	.S. 13.			anic Origin? (Sp Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		e - Americ ck, White,	
13	ad within 72 rgiene. er than "ne f, ine Medic	e Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	ction completed) College (1-4or 5+)	(Give	dent's Usual ( b kind of work DO NOT use abled	done duri retired)	ng most of work	ing 1	6b. Kind of Bu		dustry
S. Dankland	12 should be h and Mental f Is marked c	To Be	Robert L. Shipley  19a. Informant's Name/Relationship (Type	o, Print)			Street and		al Route Number,		State, Zip	Code)
46740 Baltimore	Pages 1 arment of Heamment of Heamment: If item		Donald Shipley (B  20a. Method of Disposition  1 □ Burial 2 ② Coremation 3 □ Rei  `4 □ Donation 5 □ Other (Specify)	moval Irom State 20b. P	Place of Displemetery, cre A. Fe	osition (Name matory or othe erris &	of er place) CO •	3/15/	'04 W.	oc. Location - Chest		own, State
27C	permit. Depart Import any is:		21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, or complete shock, or heart failure. List only one	ations that caused the death	Ill. 3	33 Sou	th Pa	arke St.	ral Home, , Aberde or respiratory arre	en, MD	210	001-3399 Approximate Interval Between
	ite iys	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conseq	Uence of):	IT M	161	ANO.	MA	19		Onset and Death
OLAN H'S	tt the death certifica by the attending phacehold for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic preg □ Other (spec					te of delive	ory Day Year
S NNY	aw requires that some states the states of the sound the states of the s	Completed by PI	Part II. Other significant conditions control  PERSISTE  PERIPE	ributing to death but not res	ulting in the 1 ABO2 AS Cue	underlying cau IC K IAR ,	se given i HU! DIS	n Part I. DOSIS SASE.	2	2 □ No	3 ☐ Prob	osy findings available
44)	sicien: The l scertificate ha	To Be Com	25. Was case referred to medical examiner?	spital: Impatient 2	EB/Outpatie	nt 3□ DOA	Other		perform  1 Yes 2  h (Check only one  5 Resider	No	1 🗆 Yes	mpletion of cause of 2□ No
BERT LI	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification; T	27. Manner of Death  1 Natural 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specif	28b. Time of Injury	of 280	lnjury at Work? 1 ☐ Yes	2 □No	28d. Describe how 28f. Location (Strictly or Town,	v injury occur	red	
2	To the Hospitel or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical Cert	29a. Certifying Physi	cian: To the best of my kno	wledge, dea	th occurred at	the time, n my opini	date and place, on, death occur	and due to the car	use(s) and ma	anner as st and due to	tated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	· Lith	re M	0 3	icense ni	umber -6191	29	d. Date signed	d (Month,	Day, Year)
	Sta Registr		30. Name and address of person who com  DANNSHA. SIRIT  31. Date liled (Month, Day, Year)	HARA SULL 32. Registrar's Signa	TE 206	7505	OSL	GR DRI	VE, TON	NOON	MD	21204

			For State Registrar	State	of Marylar		artment of H rtificate of I		Mental Hy	giene Reg. No. 2 (	104	09177	
			Decedent's Name (First, Middle, L			2. Date of De Month	eath Day	Year	3. Time of Death				
	Physicia		Joh			March			1715 P M				
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and nu	ımber)		4b. City, Town, or	Location of Dea	ath	4c. Count	y of Death		
			Laurelwood Care	Center			Elkton			Ced	cil		
	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		f Birth j, Day, Year)  9. Birthplace (State or Fo			
	Director		168-22-5528	1⊠M 2□F	77	Yrs.	Months Days	110010	SEPT 6	, 1926		sylvania	
	p .		Usual Residence of Decedent		10- 0	itv. Town or Lo						10d. Inside City Limits	
	rylar thow	_	10a. State 10b. County		10c. C	ity, Town or Lo	ocation					1 ☑ Yes 2 ☐ No	
	e Ma	Director	Maryland Cecil		E	lkton						23	
	2 Should be lied within 72 hours aren loadin with the waryand. Is marked other then "natural", or Itams 23a or 28a-f show aumatic event, tre Madical Examiner nust be notified at	ire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?	
		ai	123 North Tarta	n Drive			21921				ed Sta		
	r dea	Funerai	11. Marital Status	Armed F		J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? ( ın, Mexican, Pue	(Specify Yes or Ne erto Rican, etc.)	o- 14. Ra Bia	ce - Ameri ack, White,		
92	or it	٦ آ	1 Never Married 2 Married	If Yes, G	2 [X]No ive		1 ☐ Yes 2 💢 No	Specify:		Speci	fy:		
ğ	ural',	d by	3 Nidowed 4 □Divorced	Year or l	Dates:	1 40- D	d	-1:		10h Kind of I		ite	
<u>ν</u>	nat nat	Completed	15. Decedent's (Specify onfy highest of	Education trade completed	)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of w	rorking	16b. Kind of I	ousiness/in	dustry	
21215-0036	vithir ne. nen	ш	Elementary/Secondary (0-12)	College	(1-4or 5+)		chanic	"		Auto	omobil	10	
N	lled v har t	ပိ	17. Father's Name (First, Middle, La	st)		1160	ridific	18. Mother's N	ame (First, Middle			LC	
Ĕ	be f hatral } eve	Be		,									
3	ould 1 Mer nark	ို	Calvin Troy  19a. Informant's Name/Relationship	(Tuna Brint)		10b Maili	ng Address (Street		oeth Luca		State Zir	Code)	
<u>a</u>	12 st						•						
ď.	l and lealth im 2	12	John R. Troy/Sc	11	20b.	Place of Dispo	North Tar		Date	20c. Location			
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 27 is marked any injury or other traumatic evone.	1	1 Burial 2 Cremation 3		State Ar	cemetery, crei	matory or other place Gifts	<sup>(a)</sup>   Mar	ch 14,			CIO DE CONTRACT	
Ë	. Pa tmen tant: iury		`4 ☑ Donation 5 ☐ Other (Spe		Re	aistry		; 200	- <del>-</del>	Hanove	r, Ma	ryland	
3a	ermit epar npor ny in		21. Sign ture of Funeral Service Lic	ensee		H	2. Name and Addre	for Fur	nerals, I	P.A.			
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	cate be executed with the burial transit with the buri		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that ly one cause on	each line.	- 13	,	4				Interval Between Onset and Death	
		Immediate Cause (Final disease or condition a Cancer of Lung with Meta Tasis										unknown	
			Immediate Cause (Final disease or condition resulting in death)  a. Cancer Lang with Metartasis  Due to for as a consequence of:  Writing Chstrengtive Lang Disease										
			Sequentially list conditions.	b		ructive o	Ne dung Distense			UV.			
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a conse	quence of):							
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Вох	ath ca ttend or us	lan/	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy								ate of deliv Ionth	ery Day Year	
E	the a	sic	1 ☐ Yes 2 ☐ No										
P.O.	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	Part II. Other significant condition	a contributing to	doath but not re	eulting in the u	inderhina cause alv	on in Part I	23e Did	tobacco use cor	atribute to t	he cause of death?	
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of Vital Records,	w require been si should I	Completed	·	1) Tuecos	4311)				-				
ec	e law has b ye 2 st	npie							24a. Was	psy	prior to co	opsy findings available impletion of cause of	
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İta	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?						eath (Check only	опе)			
<u>_</u>	g .g .g	2	1 ☐ Yes 2 ☑ No			☐ ER/Outpatie		4 Nursing	Home 5□Res			fy)	
0 0	ng Pl fter ti nera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Dat (Mo	e of Injury onth, Day Year)	28b. Time o	Wor	k?	28d. Describe	how injury occu	rred		
ië	andii eath. or: A he fu	cati	2 Accident investigation 3 Suicide 6 Could not be 3 Suicide 6 Could not be							/2:	t and Number or Rural Route Number,		
Division	iract iract	Certification:	4 Homicide determin	286. Pla	ce of Injury - At ding, etc. <i>(Spe</i> c	home, farm, st cify)	reet, factory, office			(Street and Nun own, State)	iber or Aun	ar Houte Number,	
	ital c Irs af ral D												
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	To the Hospital or Attanding Pt within 24 hours after death. To tha Funaral Diractor: After the completely filled in by the funeral	Medical	one)	and ma	inner stated.		29c Licens	e number		29d. Date sign	ed (Month	Dav. Year)	
	Viit To Con	2	29b. Signature and title of certifier	La ol.	clevs	MIX	Dr.	002302	2	'2	5.2	och	
						(IVI)	00			ا رن	0.2	7	
			30. Name and address of person w	EV MD	use of death (Ite	8 Na	29c. Licens DO	ile 3B	, Ee	Elon 1	nD2	1921	
	St Regist	ate	31. Date filed (Month, Day, Year)	R 2 3 20	Registrar's Sig	nature	He Acord	2 3 7					
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State of Maryland / Department of Health and Mental Hygiene 2004 09178 1- State Registrar AMEND ITEM #29d PER PHY G829 3/22/06 entificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Roruary 35 Year **Physician** 1220 PM 2004 DELLA MAE VORWALD /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Easton at Faston Memorial HOSPI tai If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🕅 F Yrs. 82 JAN 17 1922 MARYLAND Director 220-01-9331 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic avant, the Modeal Examinat mast be inclined as injury or othar traumatic avant, the Modeal Examinating mast be inclined. M Yes 2 No Director MD) TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 513 N. WASHINGTON ST 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes A No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 11 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HUEY ERSKINE, SR SALLIE KIRBY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WM. J. VORWALD, JR./SON 28587 FORREST LANDING RD EASTON, MARYLAND 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 3-1-2004 EASTON, MAKYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility XELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest. 21601 shock, or heart failure. List only one cause on each line. MERCERON Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) S'eDSIS Priysician /Medical Due to (or a a consequence of): Examiner neumonia Sequentially list conditions, any learning to the date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be Acute Penal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown failure Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 🗆 Yes 2 🗌 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? the funeral director. Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. Diractor: Af 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho
To the Fune To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 55484 Haron Lacina MARCH 22,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219S. WASHINGTON ST. EASTON, MD 21601 HAROU LAURA JIN M.D. 31. Date filed (Month, Day, Year)

State Registrar 32. Signature

		1 - State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of tificate of	Health and Death	Mental Hyg	iene 2001	4 09179	
Physic /Medi		Decedent's Name (First, Middle, Last)     DONALD LEE WOI	LFE				2. Date of Death Month MARCH		3. Time of Death 3:00P M	
Exami		4a. Facility Name (If not institution, give st 4007 PEACH DRIVI				or Location of Dea	ath	4c. County of Dea	eath	
Funeral Director		212 02 1070	M 2 F		If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.		Year) C	rthplace (State or Foreign country) ASH., D.C.		
deeth with the Maryland ms 23a or 28a-f show	tor	Usuel Residence of Decedent  10a. State  10b. County  MARYLAND CHARI		ity, Town or Lo		DORF			10d. Inside City Limits	
ath with the	Il Director	10e. Street and Number 4007 PEACH DRIVI	1	10f. Zip Code	20601	10	0g. Citizen of What C	Country?		
or its	by Funeral	11. Marital Status  1 Never Married **Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ☑ Year or Dates:	1	Was Decedent of f Yes, specify Cul I ☐ Yes 2√2 No	ban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:		
vithin 72 hours af ene. then "netural", or the management of the m	Completed I	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give		during most of wed)	rorking	16b. Kind of Business/Industry		
N post	Be	12 17. Father's Name (First, Middle, Last) WILLIAM LAMAI	) MOTER	KEL	AY TEC		ame (First, Middle, A	PEPCO Maiden Sumame) ABETH EV	A MC	
Mary 12 shou h and M 7 ie mar traumat	2	19a. Informant's Name/Relationship (Type THRISA A. WOLFE-	e, Print)			t and Number or I	Rural Route Number,	, City or Town, State,	Zip Code)	
or Heal		20a. Method of Disposition  TO Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b.	Place of Dispo cemetery, cren	PEACH sition (Name of natory or other pl.	1	Date	MARYLAND 20c. Location - City o		
Baltimo permit. Page Department Important: If eny injury of		21. Signature of Funeral Service License		0 22	Name and Addi	ess of Facility D FUNER	AL SERVI	CE,P.A.	N, MARILAND	
Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the deale cause on each line.		er the mode of dy				Approximate Interval Between Onset and Death	
The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate and cer	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the to (or a consection of the to (or a consection of the to (or a consection of the to (or a consection of the to (or a consection of the to (or a consection of the to (or a consection	querice of):						
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rds, P, quires that n signed by uld be deta		Part II. Other significant conditions con	tributing to death but not re	sulting in the u	iven in Part I.		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 QUnknown			
Vital Records, sicien: The law requires to certificate has been signe rector, page 2 should be contract.	Completed						24a. Was al autops perforn 1 □ Yes 2	y prior to ned? death?	autopsy findings available completion of cause of s 2 \(\sigma\) No	
g Physier this	To Be	25. Was case referred to medical examiner?  1 Yes 2 To H  27. Manner of Death  1-Natural 5 Pending 2 Accident investigation	ospital: 1 □ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	Other		-	ath (Check only one)  ome 5□Residence 6□Other (Specify)  28d. Describe how injury occurred		
Division To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	eet, factory, office	•		I. Location (Street and Number or Rural Route Number, City or Town, State)				
the Hospit iin 24 hour the Funer spletely fills	edical	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To with	×	29b. Signature and title of certifier	Matte		29c. Licer	se number  29d. Date signed (Month, Day, Year)  3 16 2				
10		30. Name and address of person who co	mpleted cause of death (Ite	Co	1)1-1-	e M	d 2 s	0646		
Regist	tate trar	MAR 2	59	. Is	Acart	P =7				

ORIGINAL

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			1. Decedent's Nam	e (First, Middl	e, Last)						2. Dete of D	Death Dey	Year	3. Time of Dea	ath	
	Physici /Medio			Eli	zabeth J.	Willi	s				March	13 20	004	0930 AM	4	
	Examir		4e Fecility Name (/	f not institution	n, give street and n	um <i>ber)</i>				4b. City, Town, or Location of Death 4c. County of Deeth						
					re Center					Elkton		Cec				
	Funeral		5. Social Security N		6. Sex 1 ☐ M 2 ሺ F		rs. last birthday,	If Under Months	Days	If Under 24 Hrs. Hours Min.	(Month, L	of Birth 9. Birthplace (State or Foreign Country)			reign	
	Director		218-28-6582								JAN 6	JAN 6, 1930   Maryland				
	and		10a. Stete	10b. County		10c.	City, Town or Le	ocation					1	0d. Inside City Li	imits	
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	28s	9	10e. Street end Nur		11			10f. Zip	Code	(e		10g. Citizen of	Whet Coun	itry?		
	3a or	<u>-</u>	1 Price	Drive				210	921			United	R Sta	tes		
	me 2	Jera	11. Maritel Status	DLIVE	12. Was Dec	cedent Ever in	U,S. 13.			ispanic Origin? (S an, Mexican, Puert	pecify Yes or N		ce - Americ	en Indian,		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Martial Hygiane. If Item 27 is marked other than "naturel", or Hems 23a or 28e-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Directo	1 🏹 Never Merri 3 🗆 Widowed		If Yes Give				Yes 2 No Specify:			Specif				
ō	2 ho	Completed	15. Decedent's Education (Specify only highest grade comple			n	16a. Dece	dent's Usua	l Occup	ation	16b. Kind of Business/Industry					
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pu	d oth	å	17. Fether's Name							18. Mother's Name (First, Middle, Maiden Surname)						
yla	Mant Marked Marked	2	Willard	A. Wi	llis					Mabel H						
lar	and le m		19a. Informant's Na					-		and Number or Ru						
	and aalth n 27 her tr		Evelyn W		/Sister	0.05	20 P1	um Sho	ore	Road, No						
ore	Pagas 1 ant of H int: If Iter iry or oth		20a. Method of Disp	Cremation	3 Removal from	1 State	. Place of Dispo cemetery, cre	matory or ot	her plac		Date	20c. Location Cheste				
Ë	Hant:		4 Donation	5 Other (S	pecify)		hester				3/18/04	Maryla	nd			
Baltimore,	permit. Page Dapartmant of Important: If any injury or once.		21. Signature of Fu	neral Service	Licensee		H	icks	Hom∉	ss of Facility  for Fun			//	2010 Fac	7.7	
			23a. Part Lenter to	he disease, or	complications that	ceused the de	ath. Do not en	ter the mode	of dyir	ockton St ig, such as cardiac	or respiratory	arrest,	daryra	Approximate Interval Between		
	Physician /Medical Examiner		shock, or heer failure. List only one cause on each line.  Immediate Ceuse (Final disease or condition resulting in death)  Due to (or as a consequence of):													
	icata be axecuted physician and s tha burial-transit															
\		Examiner	Sequentially list conditions,  Due to (or es a consequence													
0,	e axe sian a urial-	٩	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or es a consequence of):  Due to (or es a consequence of):  Due to (or es a consequence of):													
68760,	ata b ohysic tha b	edicai	that initiated events  resulting in death) Lest  Due to (or es e consequence of):													
	artific ding p															
Вох	attand for us	Ä														
	tha e	ysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given						en in Part I.		d tobacco use co					
P.0	that the ed by datad	by Physician/M									1[	Yes 2□ No	3 Prot	ably 4 Onk	cnown	
of Vital Records,	Tha law raquiras that tha death cartificata be axecuted ata has been signed by the attending physician and paga 2 should ba datachad for usa as the bunal-transit	Be Completed by									24a. We	s an autopsy formed?	ava	ere eutopsy findir ailable prior to mpletion of causi deeth?	_	
æ	ha la ta ha: aga 2										10	Yes 20 No	10	Yes PINO		
ta	tifica tor, p		25. Wes case refer	red to medica						26. Place of Dea	nth (Check only	one)				
<b>&gt;</b>	Physician: this cartific ral diractor,	To	examiner?	No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DO	A Oth	er: Nursing H	lome 5 🗆 Re	sidence 6 □Oth	er (Specify	<i>ı</i> )		
0	ng Ph ftar th unaral	on:	27. Manner of Death  28a. Date of Injury  28b. Time of Work?  1 Natural 5 Pending (Month, Day Year)  28b. Time of Injury  28c. Injury at Work?  1 Yes 2 No								red					
Sio	Attending in death.  ector: After by the fune	catl									I Route Number					
Division	frar diffrancial in by	E	4 Homicide	determ	inted 200. Place	ding, etc. (Spe	home, farm, st cify)	reet, factory	, onice		City or T	own, Stete)	or or riara	THOSE NOMEON,		
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funerel Director: After this cartificate has compiataly filled in by the funeral director, page 2	S E	29a. Certifier	Certifyin	g Physician: To the	e best of mv k	nowledge, deet	n occurred a	at the tir	ne, date end plece	, and due to the	e cause(s) and m	anner as st	eted.		
	Hos 124 h	edical	(Check only one) A Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause end manner stated.									the cause(s)				
	Vithir Somp	Me	29b. Signature end title di certifier 29c. License number								29d. Date signed (Month, Day, Year)					
	_		+ Hom					D	54	073	15 MAR 04					
	2		30. Name end addr	ese di person	who completed ceu	ise of death (It	em 23e) (Type,	Print)			1.1	,				
	V		Arlew	Strone		81		citura	زيد	Cn	NEM	LASTLE !	DE /	9720		
	Sta Registr		31. Date filed (Moni		32.1 R 2 3 2004	Registrar's 6ig	nature	Kar	الم الم الم الم الم	p. T.						

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ORIGINAL

			For For	State of Maryland /			d Mental Hv	aiene .		00101
		1	- Stete Registrar		Certifica	ate of Death			004	
	Physicia		1. Decedent's Name (First, Middle, Last, George Richard				2. Date of De Month	Day 19, 2	Year	3. Time of Death 8:40 am
	/Medic	al -	4e. Fecility Name (If not institution, give		4b. Ci	ty, Town, or Location of D			unty of Deeth	
	Examin	er	18903 Mills Choi		Mo	ontgomery Vi		Мо	ntgom	·
	Funeral Director		213 40 0273	7. Age ( <i>In yr</i> s. last <i>b</i>		der 1 Year If Under 24 is Days Hours M	Hrs. 8. Date of Bir Min. (Month, Da Nov. 6	th y, Year) , 1946	9. Birth	nplece (State or Foreign untry)
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location					10d. Inside City Limits
	Mary First	to	MD Montg	omery	Montgome	ery Village				1 TYes 2 □ No
10	or 284	Funeral Director	10e. Street and Number	D 1	10f.	Zip Code		-	of What Co	
	9917 W	eral	18903 Mills Choic	12. Was Decedent Ever in U.S.	13. Was De	20886 cedent of Hispanic Origin specify Cuban, Mexican, P	? (Specify Yes or No		ed Sta	rican Indian,
350	be lided within 72 hours after death with the Maryland half Hygiene. Half Hygiene 43s or 28s-f show do other then "neturel", or items 23s or 28s-f show event, the Madical Examiner must be notified.	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1XXves 2 No 1964— If Yes, Give Year or Dates: 1968	· If Yes, s	pecify Cuban, Mexican, P	uerto Rican, etc.)		Black, White ecify:	e etc. white
Ò	72 ho	eted	15. Decedent's Edi (Specify only highest grad		(Give kind of	sual Occupation work done during most of	working	16b. Kind	of Business/	Industry
7	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) +4	Engine	Tuse retired)		Com	munic	ations
N I	Hygie Other t	d)	17. Father's Name (First, Middle, Last)	T4	Bugin		Name (First, Middle	, Maiden Su	mame)	
פו	should be nd Mental marked o	To B	Albert Altemus				h Burton			
	C/ G = 0		19a. Informant's Name/Relationship (7		_	ess (Street and Number of				
	1 and Health em 27 ther to	,	Sallie Gorenflo A		of Disposition (	Mills Choice	Date Date		tion - City or	
JOE I	Pages nent of ant: If it		1 Burial 2XXCremation 3 \( \text{1} \) 4 \( \text{Donation} \( \text{5} \text{)} \) Other (Specify	Hemoval from State		Crematory 3	/23/04	Belt	svill	e, MD
Baltimore,	permit. Pages Department of Important: If is eny injury or once.		21. Sign turn of Funeral Service Licens	+ Hollance	Ziname Simp 1040	and Address of Facility le Tribute F Rockville P	uneral an ike Rockv	d Crem ille,	nation MD 2	Center 0852
	5 50		23a Part 1. Enter the disease, or composite co	olications that caused the death. Done cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. MAxillary Due to (or as e consequence		s cancer				8 months
	A	er	Sequentially list conditions, if any, leading to immediate	b. Due to for as a consequence	ea of):					
/	outed id ansit	Examin	Cause (Disease or injury that initiated events	c.						
60,	e be executed /sician and e burial-transit		resulting in death) Last	Due to (or as a consequence	ce of):					
876	physic physic the b	dicai		d						
Вох 68	ath certif attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death	ath 3□Ectop	ic pregnancy (specify)		230	d. Date of de Month	livery Day Year
P. O.	that the de ed by the detached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown						
Vital Records, F	w requires that been signed I should be det	b	Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlyi	ng cause given in Part I.		tobacco use		o the cause of death?
000	e taw rec has bee	Completed					24a. Wa aut	opsv	prior to	utopsy findings available completion of cause of
Ĕ E		Com						formed? 2 X No	death?	2 □ No
Vita	Physicien: The this certificate had director, page	Be	25. Was case referred to medical examiner?	Hospital:	/O	Other	f Death (Check only		Other /Sa	noific)
of	Attending Physicien: r death. ector: After this certificator. by the funeral director.	1: To	1 ☐ Yes 2 💢 No 27. Manner of Death	1   Inpatient 2   EFV	b. Time of	DOA 4 Nurs  28c. Injury at Work?	ing Home 5 ₹ Res 28d. Describe			City)
ion	ath. r: Afte	atio	1 Natural 5 Pending 2 Accident investigation	1	Injury M	1 Yes 2 No				
Division	F 6 F C	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fa	ctory, office		(Street and I own, State)	Vumber or R	ural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical (	(Check only 2 Medical Exar	ysician: To the best of my knowled niner: On the basis of examination	dge, death occu and/or investiga	rred at the time, date and ation, in my opinion, death	place, and due to th occurred at the time	e cause(s) ar e, date and p	nd manner a lace, and du	s stated. e to the cause(s)
	o the othe	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date :	signed (Mon	th, Day, Year)
)	F 3 F ŏ	*		n - Sold	~	D43083		Ma	irch l	9, 2004
	141		30. Name and address of person who	completed cause of death (Item 23						
	W		Dr. George Soto: 31. Date filed (Month, Day, Year)	s, 9707 Medical  32. Registrar's Signature	- 4		Rockville	, MD	20850	
	St Regis	tate trar	MAR 2 4	2004 Alexandre	X Spen	E)				

Altemus, George DOD: 3/19/104

ysicia		Decedent's Name (First, Middle, Last)					2. Date of Month		y Year	3. Time of	Death
edic		Kat	thy Lee	Anders	on			H 20,2		9:24	F
amine	er	4a. Facility Name (If not institution, give st	treet and number)		1	fown, or Location o	of Death	40	County of Dee	eth	
		SUBURBAN HOSPITAL			BETHI		04 950		ONTGOME		
ral		5. Social Security Number 6. Sex 10		(In yrs. last birt 43	hday) If Under Months	1 Year If Under 2 Days Hours	Min. 8. Date of (Month)	n Birth o, Day, Year) per 16,	9. Bir	nthplece (State o	or Fore
tor	-	Usuel Residence of Decedent		+3			INOVERIL	er 10,	1900 11	rginia	
		10a. State 10b. County		10c. City, Town	or Location	· · · · · · · · · · · · · · · · · · ·			-	10d. Inside C	ity Lin
	tor	Maryland Montgomer	ry	Be	thesda					1 🗆 Yes	2X
	Director	10e. Street and Number			10f. Zip			"	izen of What C		
	ral	5802 Beech Avenue				20817			ted Sta		
	Funeral		<ol><li>Was Decedent E Amed Forces?</li></ol>		13. Was Deced	ent of Hispanic Orig ify Cuban, Mexican	gin? (Specify Yes o , Puerto Rican, etc	r No-	14. Race - Am Black, Whi		
	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	1 ☐ Yes 2	No Specify:			Specify:	White	
		15. Decedent's Educ	ation	16a.	Decedent's Usua	I Occupation		16b. K	ind of Business	/industry	
	plet	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5-	<u> </u>	(Give kind of wor life. DO NOT us	l Occupation k done during most e retired)	of working				
8	Completed	12	001090 (1 401 0 1	′	Homemak	er		Owr	1 Home		
	Be (	17. Father's Name (First, Middle, Last)					r's Name (First, Mi		Sumame)		
	2	William Lee Anders	son			Dor	othy A.	Lowry			
		19a. Informant's Name/Relationship (Typ			111		r or Rural Route N				
		Dorothy A. Anderson	n/Mother	1	U2 Beech Disposition (Nam		Bethesda				
once.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemeter	y, crematory or of	her place) M	larch 26,	Char	cation - City or lottest	ville,	
		'4 □Donation 5 □ Other (Specify)	- 1	Holly	Memorial		2004		inia		
Suc		21. Signature of Funeral Second License	7	м01035	Robert A 7557 Wisc	Pumphrey consin Aven	<sup>y</sup> Funeral Ho we, Bethes	me/Beth da, Mar	esda-Chev yland 208	vy Chase, 814-3501	, Iı
2000		23a. Pert1, Inter the disease, or complice shock, or heart failure. List only on	ations that caused to cause on each line	the death. Do r	not enter the mode	ol dying, such as	cardiac or respirato	ory arrest,		Approximat Interval Bet	tweer
in		Immediate Cause (Final disease or condition	Complicati	ions of M	yotonic Dy	strophy				Onset and	Death
al er		resulting in death)	Due to (or as a	consequence	ol):						
	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).									
	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 13 (01 42 4	consequence .	J. 7.						
	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence	of):						
	cal	d								ĺ	
	Physiclan/Med	230. Was decedent pregnant	3c. If yes, outcome of		3 □Ectopic pre	200200			23d. Date of de	alivery	
	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at t		5 Other (spe			_	Month	Day '	Year
	hys	9 XUnknown									
	ρχ	Part II. Other significant conditions con-	tributing to death bu	t not resulting ir	the underlying ca	luse given in Part I.				o the cause of c	
	ted							1 ☐ Yes 2	□No 3□P	robably 450	Unkn
	Completed							Was an autopsy	prior to	utopsy findings completion of c	avail cause
	Co							performed? es 2□No	death?		
1	Be	25. Was case referred to medical examiner?	ospital:			Othor	of Death (Check o				
	ů.	1X Yes 2 No	1 ☐ Inpatier 28a. Date of Injury			A	rsing Home 5	Residence ribe how inju		ecify)	
	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		njury M	Work? 1 ☐ Yes 2 ☐ f		100 11011 11110	, 00001100		
	Certification	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, fa	rm, street, lactory		281. Locati	on (Street ar		lural Route Num	nber,
	Cer		banding, oto	. (Opcony)			ony o	, rom, clare	*/		
	edical	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of er: On the basis of and manner stat	examination an	dor investigation,	at the time, date and in my opinion, deat	d place, and due to th occurred at the t	the cause(s ime, date and	and manner a d place, and due	s stated. e to the cause(s	s)
	Me	29b. Signature and title of certifier		00	29c	. License number		29d. Da	te signed (Mon	th, Day, Year)	
	_			1///	1	0					
		HOT ()	· M. 1	-HOVE	1	OCME		MARC	H 22,20	004	

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			i icasc i	State of Many			Jackh and A	•		10.
			1 - For State	State of Mary		artment of r <i>rtificate of</i>			/ 11	04 09183
			Registrar  1. Decedent's Name (First, Middle, Last	)		illicate of	Dealii	2. Date of De	neg. No	3. Time of Death
	Physici		BERNAPD	ARKIN				Month	1	Yeer TAOAM
	/Medio Examin		4e. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County o	
			NORTHWEST HE	SPITAL		RANDA	- CLISTON	Ne	BALT	MORE
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Bird (Month, De DEC.18	th y, Yeer)	Birthplace (Stete or Foreign Country)
	Director		561~07~2098 Usual Residence of Decedent	χ	87 Yrs.			DEC.18	,1916	VT
	yland low		10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits
	a-f et	tor	MD BALT:	MORE	PIKE	SVILLE				1 ☐ Yes 2 1 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	nat Country?
	a 23a	rai	4204 OLD MILFORI		. 110		21208		44.5	U.S.A.
	itan Para	- r	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces?	in U.S. 13.	If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black	- American Indian, , White, etc.
920	ours after death with the Marylan rai, or itams 23a or 28a-f ehow Examinat must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	1 MYes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	WHITE
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)		dent's Usual Occup	nation during most of work	cina .	16b. Kind of Bus	iness/Industry
21	within iene. than	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		MEDOLIAN	T MADINEC
	D 70 = -		17. Father's Name (First, Middle, Last)		MERCI	IANT SEAM	1	e (First. Middle.	MERCHAN Maiden Sumame	T MARINES
ano	<b>7</b>	To Be	WILLIAM		ARK]	N	RACHEL		SOKOLO	
Maryland	shound N	-	19a. Informant's Name/Relationship (T)	rpe, Print)			and Number or Ru			
	コニトン		SHEILA BUCHDAHL	/ NIECE	702	OLD CROS	SING DRIV	E - PIK	ESVILLE,	MD 21208
ore	of T		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ F	Removal from State	Ob. Place of Dispo cemetery, crea	sition (Name of matory or other pla	<sub>сө)</sub> PARK	Date	20c. Location - C	City or Town, State
Ë			*4 □Donation 5 □Other (Specify)			OM MEMOR		/2004		ERSTOWN, MD
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licens	99		2. Name and Addre				OS., INC.
	10100		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the						LE, MD 21208
			Immediate Cause (Final	ne cause on each line.			1	7 - 1	. 1	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as a co		cardia	7 21/	Las Cil	CON	
	Examiner		Sequentially list conditions	b				2		
	p is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that satisfact are on the cause)	Due to (or as a co	nsequence of):					
_	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):					
200	te be executed ysicien and ie burial-transit	calE		·	, ,					
687	leath certificate b attending physic I for use as the b			d						
Вох	th cert endin	an/M	230. Was decedent pregnant	23c. If yes, outcome of pr		Ectopic pregnance	v			of delivery
	e dea the att	Physician/Med	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at time 9☐ Unknown		Other (specify)	<u></u>		Mont	h Day Year
P.O	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be delached for use as th		9 ☐ Unknown  Part II. Other-significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause giv	ven in Part I	23a Did to	obacco use contrib	oute to the cause of death?
Records,	signe d be	d by	Sepsis	g to dod ogt	. rosanny m mo o	naony ing occaso gn	or are are a			Probably 4 nknown
CO	w require been si should t	Completed						24a. Was	an 24b We	ere autopsy findings available
Re	The lav	dwo						autop perfo	osy pri imu <sub>l</sub> ad? de	ior to completion of cause of ath?
Vital		a	25. Was case referred to medical				26. Place of Dear	1 ☐ Yes	1	Yes 283No
Ţ	S S S	To B	examiner?	Hospital: 1 Ninpatient	2 ER/Outpatier	nt 3 DOA Ott	ner .		dence 6 □Other	(Specify)
n of	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	Wor	ry at	28d. Describe h	now injury occurred	t
sio	Attending in death. ector: After by the fune	cati	Accident investigation  3 Suicide 6 Could not be	Do Bloom Maine	A1 h === 4		Yes 2 □No	00/ 1	Ot	
Division	or Attendate death Director:	Certification:	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	pecily)	eet, lactory, office		City or Tov		r or Rural Route Number,
_	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:		29a Certifier 1 Certifying Phy	sician: To the best of my	knowledge, deat	h occurred at the tir	me, date and place,	and due to the	cause(s) and manr	ner as stated.
	n 24 t n 24 t he Fu pletely	edicai	(Check only 2 Medical Examione)	ner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my o	ppinion, death occur	red at the time,	date and place, an	d due to the cause(s)
	To the Complex of the	Σ	29b. Signature and title of certifie		X	29c. Licens	e number		A 1	(Month, Dey, Year)
	1)		1) ey/	Joseph	MO	リクと	735		March	21,2004
	0		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type,		er el	NDA	NWOTE	MD 71172
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S		COURT "	The last	TYPECE	/(00019	-1177
	Registi		MAD 9 / 2004		H Ann	de o				

			1 - For State Registrar		Maryland /	Departm Certific	nent of He	ealth and M Death		Reg. No.	14 09184
•	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Virginia B. Bu      Aa. Fecility Name (If not institution, so Sinai Hospital	inham give street and number	er) Uti more	_	City, Town, or	Location of Death	2. Date of De Month Kazek	Day Y	3. Time of Death OO4 3. 30 A M Death
Lind	Funeral Director			. Sex 7	Age (In yrs. last b	irthday) If L	Inder 1 Year Inths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 10/31,	th ly, Year) /1928	Birthplace (State or Foreign Country) MD
VIKETINA	death with the Maryland ims 23s or 28s-1 show	ctor	10a. State 10b. County	/A	10c. City, Tov	wn or Location	Hampda	en			10d. Inside City Limits 12€Ses 2 □ No
, HH	ath with the 23a or 28 ust by fre	rai Director	10e. Street and Number 2921 Keswick Road			10	f. Zip Code <b>2121</b>	1		10g. Citizen of Whated	•
15 CL R NOTATH 5-0036	19 E	ed by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced	If Yes, Give Year or Date:	s? ▼No s:	1 🗆 Y	es XXX No	panic Origin? (Spo , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify:	American Indian, White, etc. white
fatient Known on 15 CKP. Baltimore. Marvland 21215-0036	2 should be filed within 72 hc and Mental Hygiene. Ia marked othar than "natur aumatic event. In Musical	Completed	15. Decedent's (Specify only highest (Specify only highest (12))	grade completed)  College (1-40		(Give kind o life. DO No	mamaker	uring most of work			Hame
्र Vland	2 should be fi and Mental H is marked ott sumatic ever	To Be	17. Father's Name (First, Middle, La Thomas Yeager  19a. Informant's Name/Relationship		100	h		Bertha	Sherman		
Krewin e. Marv	1 and 2 st Health and tam 27 iar		Harry Lee Burnham  20a. Method of Disposition			2921 Kes	wick Roa	d, Baltimo	re MD 2]		
fiztient Baltimor	permit. Pages 1 and 2 should Department of Health and Men Important: If flam 27 is market any injury or other traumatic once.		1 ☑ Burial 2 ☐ Cremation 3	cify)	te Garris	on Fores	t VA Ceni	March 25	2004	_	ls Maryland
tet Baj	permit. Departm importa any inju		21. Signature of Funeral Brytoe Lic	ensee Victor I	P. Doda, Ji	Chart	e and Address Es L. Sto East For	of Facility Evens Fune: t Avenue, I	al Home,	Inc. MD 21230	
•	Physician /Medical Examiner	i Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ce velo Due to (or a b. Due to (or a	i line.	cular of):		such as cardiac c	r respiratory a	rrest,	Approximate Interval Between Onset and Death 1 Week
.O. Box 68760,	eath certificate attending phys	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death		ic pregnancy r (specify)			23d. Date o Month	f delivery Day Year
rds, P	w requires that been signed b		Part II. Other significant conditions Adrial fibrical	contributing to death		in the underlyi		in Part I.			te to the cause of death?  Probably 4 Unknown
al Reco	ician: The law re certilicate has be ector, page 2 sho	e Completed by	Diehetis Hel	etus						an 24b. Wer sy prior med? deat 2 No 1	
Division of Vital Records, P.O.	Attanding Phyaician; r death. ector: After this certifica by the funeral director.	To B	25. Was case referred to medical examiner?  1 Yes 2 No  27. Magner of Death 1 Natural 5 Pending investigat	28a. Date of In (Month, L	ntient 2 ER/On njury 28b.	utpatient 3 Time of Injury	DOA Other 28c. Injury a Work?	at 2	ne 5 ☐ Resid	lence 6 Other (	Specify)
Divis	Hospital or Attan 4 hours after deat Funaral Director: tely filled in by the	Certification;	3 Suicide 6 Could not determine	d 28e. Place of I	njury - At home, fa etc. <i>(Specify)</i>	arm, street, fa	ctory, office	2	8f. Location (S City or Tow		r Rural Route Number,
	P F S S S S S S S S S S S S S S S S S S	edicai	29a. Certifier 1 Certifying I (Check only one) 4 Medicel Ex	Physician: To the bes eminer: On the basis and manner:	of examination ar	e, death occu nd/or investiga	red at the time tion, in my opin	, date and place, a nion, death occurre	nd due to the ded at the time, d	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the within To the comple	M	29b. Signature and title of certifier	es houté	- (YI)		29c. License		1	29d. Date signed (N Herch	
	b		30. Name and address of person wh	o completed cause of AUSKAITE	death (Item 23a)		SINAL	HOSPIT	46 0	F BALT	23, 2004 THORE
	Sta Registr		31. Date filed (MAR 2 4 20		strar's Signature	houth				PI	

			1- For State of Maryle Registrar	and / Depa <i>Ce</i>	artment of H rtificate of L	ealth and M Death	fental Hygi	ene 20	04 09185
			Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
	Physici /Medic		Norman Thompson Br	rown	310		March		04 1545 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	Death
			Union Hospital		Elkton	If Under 24 Hrs.	12.2	Ceci	
	Funeral Director		219-18-9473 <sup>1∑M 2□F</sup> 78	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, April 27,	1925	Birthplace (State or Foreign Country) Maryland
	and		Usual Residence of Decedent  10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Marylan -f show Ind at	ξ	Maryland Cecil	Elkton					1 ∑Yes 2 No
	death with the Maryland me 23a or 28a-f show rmust be notified at	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wha	at Country?
	23a c	aiD	506 Hollingsworth Avenue		21921			United	States
	er de s	Funeral	11. Marital Status  12. Was Decedent Ever in Armed Forces? WO	rId 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Americen Indian, White, etc.
5	irs afte	by F	IT TES, GIVE	Nar II	1 ☐ Yes 2🂢 No	Specity:		Specify:	White
2-0020	2 hou	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupa		1	6b. Kind of Busin	
7	be filed within 72 hours after death with the Maryla ital Hygiens "natural", or litame 23a or 28a-f shov other than "natural", or litame 23a or 28a-f shov event, the Madical Examinat mant be notified at	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done d DO NOT use retired)	uring most of work	ing	Automo	bile
V	ygien ygien rt. the	Соп	2	Acc	ounting				cturing
yiarid		Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	_	aiden Sumame)	
Ž	ges 1 and 2 should to f Heath and Mer if item 27 is marke or other treumatic	2	Charles Brown  19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a		Snyder	City or Town. Sta	ute Zin Code)
<u> </u>	and 2 sealth and 2 sealth and 27 is ner treu		Frances J. Brown/Wife				,		land 21921
ני ע	of Heal		20a. Method of Disposition 20	b. Place of Dispo			Date 2	0c. Location - Cit	
Dallillore	Pages nent of int: If it iny or o		1 🔀 Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)	lkton C		<sup>9)</sup> March 2004		Elkton.	Maryland
<u> </u>	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licensee	27 H	Name and Addres	s of Facility			arry turns
0	207		Donaid S. Dicks	ا 1 ا	03 W. Sto	ckton Str	eet, Elk	ton, Mar	yland 21921
			23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	eath. Do not ent	ter the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	POXIA	1				
	Examiner		Due to (or as a con	sequence or):	Δ				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		, / )				
•	acuted and transi	Examiner	Cause (Disease or injury that initiated events c.						
Š	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a con-	sequence of):					
07700	ires that the death certificate be executed signed by the attending physician and deedeteched for use as the burial-transit	dical	d						
YOU	death certific e attending p id for use as	hystcian/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre		7=			23d. Date o	f delivery
	death	lcia	in the past 12 months?  1 \( \text{Yes bound past 12 months} \)  1 \( \text{Yes 2} \)  No  9 \( \text{Unknown} \)		☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
5	at the	Phys	9 🗆 Onknown						
ń	requires that the een signed by th hould be detache	δ	Part II. Other significant conditions contributing to death but not  // OPCS ABLE That ACLO	-	inderlying cause give	n in Part I.	23e. Did toba		te to the cause of death?
	requ	eted	(	7500	01   300		, ,		
ב ט		ompleted	Severe EmphysemA				24a. Was an autopsy perform	prio	e autopsy findings available r to completion of cause of th?
Vital Records,		e Co	25. Was case referred to medical			26. Place of Deatl		7	Yes 2 No
>	ysician: Is certific director.	0	examiner? / Hospital:	ER/Outpatier	nt 3 DOA Othe		me 5 Resider		Specify)
5	ding Ph h. After th tuneral	n: T	27. Manner of ath 1 XNatural 5 ☐ Pending 28a. It to of Injury (Month, Day Year	28b. Time o	f 28c. Injury Work		28d. Describe how		
2	tendii eath. tor: A	catic	2 Accident investigation			es 2 □No			
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Certification:	4 Homicide determined 28e. Place of Injury - A building, etc. (Sp.	.t home, farm, sti acify)	reet, factory, office		City or Town,		or Rural Route Number,
	spitel		29a. Certifier 1☑ Certifying Physician: To the best of my	knowledge, deat	h occurred at the tim	e, date and place,	and due to the car	use(s) and manne	er as stated.
	n 24 t	edical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	ination and/or in	vestigation, in my op	inion, death occurr	ed at the time, da	te and place, and	due to the cause(s)
	To t	Ž	29b. Signature and title of certifier		29c. License				fonth, Day, Year)
	11		Chemas M. Vugga	n	Do	5913/		1ARCh,	17,2004
	41		30. Name and address of person who completed cause of death (			•	7 9 ~ ~ ~	0.7	
	Sta	ite	Thomas M. Dugan, M.D., 207 N 31. Date filed (Month, Day, Year) 32. Registrar's Si		reet, Elkt	on, Mary	Tand 219	71	_
	Registr		MAR 2 4 2004 ▶	in A	Goods of	٧			

			1 - For State Registrar	State of	of Marylan	id / Depa	artment of F	lealth and Death	Mental Hyg		004	09186
			Decedent's Name (First, Middle,	Last)			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Dear	eg. No.		3. Time of Death
	Physici		Mary C.		Biano	7.7			Month March	Day 21	Year 2004	9:00 A M
	/Medic Examin		4a. Facility Name (If not institution,	give street and nu		Ja	4b. City, Town, o	r Location of Dea			nty of Death	9:00 A
	Lxarim		313 Fifth Avenu	e S.E.			Glen Bu	rnie		Anne	Arund	le1
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr				lace (State or Foreign try)
١.	Director		214-48-2006	1 □ M 2 □XF	92	Yrs.	Months Days	Hours Mir	March 4			land
	p ,	Ì	Usual Residence of Decedent		10- 00							
	anyla ahov	_	10a. State 10b. County Maryland Anne	Arundel		y, Town or Lo len Bur					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	Director				ich bul						
	Mith t		10e. Street and Number	-			10f. Zip Code		1		of What Coun	•
	eath	erai	313 Fifth Avenu		edent Ever in U.	C 12.1	21061		Specify Yes or No-		d Stat	
	ter d	Funerai	1 ☐ Never Married 2 ☑ Marrie	Armed F		.3.	Yes, specify Cuba	an, Mexican, Pue	erto Rican, etc.)		lack, White,	
99	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or D	ive		☐ Yes 2 🔀 No	Specify:		Spec	cify: Wh	ite
21215-0036	2 ho	Completed	15. Decedent			16a. Deced	ent's Usual Occup	ation		16b. Kind of	Business/Inc	lustry
2	thin 7	ρie	(Specify only highest Elementary/Secondary (0-12)	T	1-4or 5+)	life. L	kind of work done OO NOT use retired	during most or wi	orking			
7	gien gien erth	Con	6			Home	maker			Ow	n Home	!
p	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther then "natural", or items 23a or 28a-f ahow do ther then "natural", or items 23a or 28a-f ahow event, the Mcdical Examiner must be notified at	Be (	17. Father's Name (First, Middle, L	ast)				18. Mother's Na	ame (First, Middle, I	Maiden Sum	ame)	
yla	Ment Ment arke	2	Corcordio Amas	cato				Paula I	DiMaria			
Maryland	2 sh and Ism	1	19a. Informant's Name/Relationsh						Rural Route Number			
e)	l and lealth im 27 ther t		Frank G. Bianca	Jr S			Sition (Name of	- T	Glen Bu			061
Ö	it of h		20a. Method of Disposition  1 ★ Burial 2 ☐ Cremation	3 □Removal from		emetery, cren	natory or other place	(e) Marc	ch <sup>Date</sup> 25	20c. Location	n - City or To	wn, State
Baltimore,	t. Partmer		'4 □ Dorlation		Gle		n Mem. P		04 _(	Glen B	urnie,	Mary1and
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene "natural", or Items 28a or 28a-1 ahow any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fugers' Service L	J.		Rir	Name and Addre kley-Rud 421 Crai	dick Fur n Highwa	neral Home	P.A. Slen B	urnie,	21061 Maryland
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that	caused the deatl	h. Do not ente	er the mode of dyin	ng, such as cardia	ac or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		f	verw.	mo					Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):		1.				
	LAGITIME		Sayuentially list conditions if any, leading to immediate	b	10	vkm.	ran's o	liteast				
	ed sit	iner	cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	uence ot):						
7	and and al-trar	Examin	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):					_	
8760,	icate be executed physician and s the burial-transit	dicai E										
		edic		d								
Вох	nding nding use a	M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna					23d. C	Date of deliver	v
m	death e atte d for	Physician/M	in the past 12 months? 1 2 Yes 2 No	4□Pregi	birth 2 Tetal nant at time of de		Ectopic pregnancy Other (specify)			1		Day Year
o.	t the by the ache	hys	9 Unknown	9□ Unkn	iown							
ď.	The law requires that the death certifi te has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant condition	s contributing to d	/\		derlying cause give	en in Part I.	23e. Did tob	acco use co	ntribute to the	e cause of death?
Records,	w require been sig should b				Decuh	(1/2)	Uler		1 ☐ Ye	s 2 🖰 🗚	3 ☐ Proba	ably 4 □Unknown
၁၁	e law requ has been je 2 shoul	Completed							24a. Was ar		. Were autop	sy findings available apletion of cause of
		mo:							autops perform	red?	death?	
Vital	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					26. Place of De	eath (Check only on	9)		
<u> </u>	Physic this co al dire	၉	1 ☐ Yes 2 PNo	Hospital: 1 🗆	Inpatient 2	ER/Outpatien	3□ DQA Oth	er: 4 🗌 Nursing	Home 5 eside	nce 6 🗆 O	ther (Specify	)
Division of	ng f fter iner	on:	27. Manner of De th  1 Anatural 5 ☐ Pending	28a. Date (Mon	of Injury oth, Day Year)	28b. Time of Injury	28c. Injun Worl	y at k?	28d. Describe ho			
Sio	Attendi death. ctor: A y the tu	cati	2 Accident investigation 3 Suicide 6 Could not	ot be				Yes 2 □ No				
<u> </u>	I or Atten after deatl Director: I in by the	Certification:	4 ☐ Homicide determin	and 200. Flace	e of Injury - At ho ing, etc. (Specif)	ome, farm, stre v)	et, factory, office		28f. Location (Sti City or Town		nber or Rural	Route Number,
_	Hospital 4 hours a Funeral I tely filled	2	29a. Certifier 1 Certifying	Physician: To th	a hast of my kno	wlodgo doath	geograph at the time	no, date and place	e, and due to the ca			
	To the Hospital or Attenwithin 24 hours after deating to the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical E	xaminer: On the b	pasis of examinal iner stated.	tion and/or inv	estigation, in my o	pinion, death occ	urred at the time, da	ite and place	and due to	the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier	Λ			29c. License				ned (Month, D	
)			1 th	Ilim	~		- //	14715	1 0	nevel	6,23	, 2004
	5		30. Name and address of person w	no completed cau	se of death (			/ h.	0 0 - 4			10 t
			31. Date filed (Month, Day, Year)	UES M	Registrar's Signa		roop No	CLEV	7 le Jenny	t m	) 2/	061
<b>6</b> .	Sta Registr		MAR 2. 1		Agustar's Signa		Ann.	11				

			For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of H tificate of L	ealth and I D <i>eath</i>	Mental Hyg	giene 10g. No. 20	04	09187
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Edgar Stan	ley Be	auchar	np-Nobbs		MAR	22 2	-004	2:15 A M
	Examin	er	4a. Fecility Name (If not institution, give s			4b. City, Town, or		1	4c. County		
			Futurecare - Che  5. Social Security Number 6. Sex		ast hirthday)	Arnolo	If Under 24 Hrs.	8. Date of Birth		Arun	del ece (State or Foreign
П	Funeral Director			M 2□F 87	Yrs.	Months Days	Hours Min.	April 1	, Yeer) 5,1916	Coun	Jersev
	D		Usual Residence of Decedent						, , , , ,		
	arylar ahow		10a. State 10b. County		, Town or Lo	cation				10	0d. Inside City Limits 1 Yes 2 XNo
	the M	ecto	MD Anne Aru  10e. Street and Number	ndel Ar	nold	10f. Zip Code		1.	10g. Citizen of V	What Coun	
	with Sa or	ă	1475 Grandview R	oad		210	12		US		.,,
	death	Funeral Director		2. Was Decedent Ever in U.	S. 13.	Was Decedent of Hi	spanic Origin? (S	pecify Yes or No-	14. Rac	e - America	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ahow any injury or other traumatic avent, the Medical Examiner must be notified at ance.	þ	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	Armed Forces?  1    Yes 2 □ No  If Yes, Give  Year or Dates: WWI	_	f Yes, specify Cuba 1 □ Yes 2🏹 No	Specify:	o Mican, etc.)	Specify	ck, White, e	hite
2-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa	ation	kina	16b. Kind of Bu	usiness/Inc	lustry
21	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	)	, , , ,			
121	iled w lygier her th		17. Father's Name (First, Middle, Last)	4	Naval	Engineer		ne (First, Middle,	Naval :		on
Maryland	d be f antal h sed of	) Be	Stanley Beauchamp-	Nobbe			Dore Ra		Walder Corre	,	
Z	should mark mark	ဥ	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street a			r, City or Town,	State, Zip	Code)
	alth al		Chereen McNellis	(Daughter)	40 I	incoln Pl	lace, Lil	erty NY	12754		
ore,	es 1 a of He item		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ R	20b. P	lace of Dispo	sition (Name of natory or other plac	θ)	Date	20c. Location -	City or To	wn, State
Ĕ	Pag ment ant: h		*4 □Donation 5 □Other (Specify)			ematory	-	3/2004	Baltimo	ore,	MD
Baltimore,	Depart Import any inj once.		21. Signature of Funeral Service License	ye.	22	Name and Address Hardesty 12 Ridge	Funeral  V Avenue	Home P.A	A.	214	0.1
			23a. Part1. Enter the disease, or compile shock, or heart failure. List only or	cations that caused the death	. Do not ent						Approximate Interval Between
125	Physician		Immediate Cause (Final disease or condition	END STA	GF	COPD					Onset and Death
M	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						
16.		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):						
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events								
o,	exec an an	Exa	resulting in death) Last	Due to (or as a consequ	uence of):						
8760,	cate be executed physician and the burial-transit	dlcal									
Φ		0	IF FEMALE:	0-16						ľ	- 33
Box	The law requires that the death certifi tte has been signed by the attending I bage 2 should be detached for use as	Physician/M	in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3[	Ectopic pregnancy Other (specify)				te of delive inth	ry Day Year
o.	at the de by the a tached	yslo	1 U Yes 2 No 9 Unknown	9 Unknown	3 L						
٦,	s that ned b e deta	by Pt	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
rds	w requires been sign should be	ed t	SEVERE P	ULMONAK	24 /	HYPERT	ENSION	137	es 2□No	3 Prob	ebly 4 Unknown
Records,	e law re has be	Completed						24a. Was a autop		Nere autor	sy findings available
H		Corr						perfor	med?	death? 1 🗌 Yes	
Vital	ician: T certificat ector, pa	Be	25. Was case referred to medical examiner?	lospital:		Oth	0.0	ith (Check only or			
of	this aldin	- To	1 Yes 2 No	1 Inpatient 2 28a. Date of Injury	ER/Outpatier 28b. Time o		4 Linear sing P	ome 5 Resid			)
O	After	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Worl	(? Yes 2 □ No	200. Describe ii	ow injury occur	60	
Division	or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho	me, farm, sti	eet, factory, office		28f. Location (S	treet and Numb	er or Rura	Route Number,
D	ospital or A hours after uneral Dired ly filled in by	Certification:	4   Homicide	building, etc. (Specify	′)			City or Tow	n, State)		
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	cal	(Check only 2 Medical Exami)	sician: To the best of my kno ner: On the basis of examinal and manner stated.	tion and/or in	vestigation, in my or	pinion, death occu	rred at the time, o	late and place.	and due to	the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signe	d (Month, I	Day, Year)
	1		msnegi	Nes		D.	57531		Mar	eh	22 2004
	1/2		30. Name and address of person who co	impleted cause of death (Item	23a) (Type,	Print)	,				
	CONTRACT OF		Monit Negi	8601 VEZ	en	ns the	Shewar	1, mil	resu	Uc	NO Zuos
	Sta Regist	ite rar	29b. Signature and title of certifier  Mark 2 4  29b. Signature and title of certifier  Mark 2 4	2014 Asserts Signa	iure Ja	1.00 B. 5		, -			
		0	131111 4 2	7.3 C. C. C.	"Ten?"	Maria Comment					

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of M	•	•	ificate of	Death		Reg. No. 2	004	09188
	Dhyaiai		1. Decedent's Neme (First, Middle, Las		. ,,,,,				2. Date of De		Year	3. Time of Death
	Physici /Medio		Isaac Charles							20, 200		2:05 am
	Examir	ier,	4a Fecility Name (If not institution, give	street end number,	)			4b. City, Town, or			y of Death	
_			Casey House  5. Social Security Number 6. Se	ex 7. Ac	ge (In yrs. lest bir	thday)	If Under 1 Year	Rockvil	8 Date of Bir	th.	ntgom 9. Birtho	
	Funeral Director					Yrs.	Months Days	Hours Min	. (Month, Da	sy, Year) 5 <b>,</b> 191	3 N	place (State or Foreign htry) ew York
	land		10a. State 10b. County		10c. City, Tow	n or Loca	ation				1	0d. Inside City Limits
	Man a-f sh	ģ	MD Montg	omery	Si	lver	Spring					XXYes 2□No
	or 28	ž.	10e. Street and Number				10f. Zip Code	-		10g. Citizen of	Whet Cour	ntry?
	ath w	rai	10209 Gardiner A				209			United		
Maryland 21215-0020	be filed within 72 hours efter death with the Maryland stel Hygiene.  Ide thygiene and the stellar or items 23a or 28e-f show event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 If If Yes, Give Yeer or Dates:	7		as Decedent of H Yes, specify Cub □Yes XXXNo	dispenic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Speci	ce - Americ ack, White, fy: Wh:	
2-0	72 hou	ğ	15. Decedent's Ed	ucation	16e.	Decede:	nt's Usual Occup	petion	arkin a	16b. Kind of E	Business/In	dustry
7	thin 7	npie	(Specify only highest gre- Elementary/Secondary (0-12)	completea) College (1-4or	5+)			during most of wo d)	rking	Uni	ted S	tates
121	ygien ygien ver th	S	12			Mili	itary	42 44 41 4 44	(F) . A(:///	Go	vernm	
and	4 de 4	Be	17. Father's Name (First, Middle, Lest)  Charles Augustu	c Romic					me (First, Middle Beatric		•	
Ž	12 should be the end Mentel I is marked of traumatic even	မ	19a. Informant's Name/Relationship (7		19b	Mailing	Address (Street	and Number or R				Code)
Ma	C1 0 0 0		Julia Bemis/Wife	e, Silv								
ē,	of Health Item 27 I		20a. Method of Disposition		20b. Place of		tion (Neme of story or other pla		Date	20c. Location		
Ē	Page nent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	ory	3/23/0	4 Bel	tsvil	le, MD				
Baltimore,	permit. Pages 1 end Depertment of Health Important: If Item 27 any Injury or other th		21. Signature of Foneral Service Licen	LANO	Jano	/ S:	Name and Addre	ss of Facility ibute Fu	meral a	nd Crema	ition	
	3,,	$\Box$	3a. Part1. Enter the disease, or complete hock, or heart failure. List only of	olications that cause	d the death. Do r	not enter	the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	ΉΣ Ζ(	)852 Approximate Interval Between
ia <sub>rd</sub>	Physician		snock, or neart failure. List only to	one cause on eech i	ine.							Onset and Death
1	/Medical Examiner		Immediate Cause (Final disease or condition	. Bla	dder Car	ncer					:	Months
	Examiner	disease or condition resulting in death)  Bladder Cancer  Due to (or as a consequence of):										
	bed sit	nine		b							1	
oʻ	The law requires thet the death certificete be executed ate has been signed by the attending physician end page 2 should be delected for use es the bunet-trensit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events		Due to (or as a	conseque	ence of):				†	
68760,	ete be hysici the bu	lical	that initiated events resulting in death) Last	C	Due to (or as e o	onseque	ence of):					
	ing pl	ALC: U		d							1	
Вох	ath co	lan/		u								
	he de	Physician/N	Part II. Other significent conditione co	entributing to death b	out not resulting in	the und	lerlying cause giv	en in Pert I.				the cause of death?
P.O.	s that t ned by e dete	by Ph							10	Yes 2□ No	3 ☐ Prol	oably 4 ☐ Unknown
Records,	requires that the de been signed by the s should be deteched									an autopsy ormed?	ava	ere autopsy findings allable prior to
3ec	The law rate has be page 2 sh	Completed								v	of	mpletion of cause death?
<u>a</u>			25. Was case referred to medical							Yue 3X2140	1[	Yes 2 No
Vital	ysicia s certi directe	o Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	tnatient	3□ DOA Oth		ath (Check only o	-22-11-3	ner (Specif	// Hospice
10	5 E E	-	27. Manner of Death	28a. Date of Inju	ıry 28b. 1	ime of	28c. Injur	y at		how injury occu		Home
io	tending Fleath. tor: After the funer	ate	1 ⚠ Natural 5 ☐ Pending investigation		, , , , , , , , , , , , , , , , , , , ,	ıjui y		Yes 2 □ No				
Division	or Attendin efter death. Director: Aft d in by the fur	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Zoe. Flace of In	iury - At home, fa c. (Specify)	rm, stree	t, factory, office		28f. Location ( City or To		ber or Rura	l Route Number,
	Hospita 24 hours Funeral tely filled	Medical C	29a. Certifier (Check only one)	rsician: To the best Iner: On the basis o end manner st	of my knowledge f examination and ated.	, death o	occurred at the tir stigation, in my o	ne, date and plece pinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certification	20/			29c. Licens	e number		29d. Date sign	ed (Month,	Day, Yeer)
	, , , \		XXXX	1/cc	_		DØ	\$4112	18	Marc	h, 2.	2,04
	5		30. Neme end address of person who co					Road Roc	kville,	MD 208	50	
Ī	Sta Registr	to.	31. Date filed (Month, Day, Year)		er's Signature	hos	retel					*

ORIGINAL

DHMH 16 Rev 6/95

CPM 04-02006 MARGARET BESTE-RUSSELL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2001

			1 - For State Registrar	Olato or Illa	Ce	ertificate of L	Death		Reg. No.	104	0318
	Dh		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	Voar	3. Time of Death
	Physic /Medi		Margaret A. Best	e-Russell	<u> </u>			March	21, 20	004	15:08 M
	Examir		4a. Facility Name (If not institution, give : 909 Green Fawn Co			4b. City, Town, or Abing			4c. County Hari		
	Funeral Director			M 2☐ F 7. Age 39	(In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day May 29,	y, Year) 1964	Coun	lace (State or Foreign try) Yland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation		70.5		11	Od. Inside City Limits
	ath with the Marylan s 23a or 28e-f show and he notitied at	ctor	Md. Harford		Al	ingdon					1 ☐ Yes 2X No
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V		
	s 23e	-Ea	909 Green Fawn C		main U.C. 40	2100				ed St	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Modical Extralinational pages.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar  1 ☐ Yes 2 ☐ XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecry Yes or No- Rican, etc.)		e · America k, White, e white	etc.
21215-0036	in 72 ho	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Giv	edent's Usual Occupa e kind of work done di DO NOT use retired)	uring most of work	ing	16b. Kind of Bu	isiness/Ind	lustry
212	d with giene or the	mo	Elementary/Secondary (0-12)	College (1-4or 5+	-)	wrapper			food s	tore	
p	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	., .,	Maiden Sumam	Θ)	· · · · · · · ·
yla	Men J Men narke	Lo	Juergen Beste				Gisela I				
Maryland	d 2 sh th and 17 Is n traun		19a. Informant's Name/Relationship (Ty) Paul J. Russell/			ing Address (Street at Green Faw)					
ē,	s 1 an f Heal Item 3		20a. Method of Disposition			osition (Name of ematory or other place		Date	20c. Location -		
E O	Page:		1 GBurial 2 ☐ Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		<i>la</i> 11ey Mem		3/25/04	Timoniu	m, Mo	ł.
Baltimore,	permit. Departm Importe any inju		21. Signature of Funeral Service License  Bering C	0.00	2	2. Name and Address Schimunek	of Facility Funeral	Home of	Bel Ai	r, Ir	
68760,	The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate and and an incidence of the certificate and an incidence of the certificate and an incidence of the certificate and an incidence of the certificate and an incidence of the certificate and an incidence of the certificate and an incidence of the certificate and an incidence of the certificate and an incidence of the certificate and an incidence of the certificate of the certificate and an incidence of the certificate of the		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or se a	consequence of):	shot w	ound i	of he	ed_		Onset and Death
Box 68	eath certificat attending phy for use as the	lan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 □ Live birth 2	Fetal death 3	□Ectopic pregnancy	-		23d. Date Mor	of deliver	ry Day Year
P.0.	that the de led by the a detached f	Physician/I	1 ☐ Yes 2 ☐ No 9 X Unknown	4□Pregnant at ti 9□ Unknown	me of death 5	Other (specify)			14101		ouy rour
Records, P.	uires that signed by Id be deta	by	Part II. Other significant conditions con	tributing to death but	not resulting in the t	underlying cause giver	n in Part I.	23e. Did tol	.1		e cause of death?
COL	tw requires s been si should l	Completed						24a. Was a	an 24b. V	/ere autop	sy findings available
	The lav	omp						autops perform	sy p med? d	rior to com eath?	pletion of cause of
Vital		Be C	25. Was case referred to medical examiner?				26. Place of Death	1 Check only on	T 17 6	185	2□ No
of <	Physician: r this certific ral director,	P P	1X Yes 2 No H		2 ER/Outpatie		4   Nursing Ho	me 5 Reside	ence 6 💆 Othe	r (Specify)	SCENE
ion	Attending Property of death. Sector: After by the funeral	atlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	1	. O Work	at es 2 Dayo	28d. Describe ho	w injury occurre	Show	tse IF
Division	in Site	Certification:	3 Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (St City Toyu		r or Rural	Route Number,
	To the Hospital or / within 24 hours after To the Funerel Dire completely filled in b	edical	29a. Certifier (Check only one)  1 Certifying Phys	ician: To the best of er: On the basis of e and manner state	xamination and/or in	th occurred at the time evestigation, in my opin	a, date and place, a nion, death occurr	and due to the ed at the time, d	se(s) and mar ate and place, a	ner as sta	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Sign at re and title of ce and r		00	29c. License	number	2	9d. Date signed	(Month, D	Pay, Year)
,	20	3	etallio	-18	Colore	0.	.C.M.E.	3-1	March 2	2, 20	004
	10		30. Name and address of person who con	mpleted cause of dea		Print) 1 Penn Sta	reet, Bal	Ltimore.	Marvla	nd 21	201
			31 Date filed (Month Day Year)	17,01	- MAN		-,				

DHMH 17 Rev 1/2001

Registrar

MAR 2 4 2004

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Helene Briers 3:30P M March 21 2004 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2K) F 218-07-6031 Director 85 Oct 23,1918 Maryland Usual Residence of Decedent f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Howard Ellicott City Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3101 Elmmede Road Items 23a 21042 U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ ∑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than \*natural', or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2+ Baltimore City School Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Karl Otto Kretzschmar Ida M. Harm 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 Elmmede Road Ellicott City, Maryland 21042 Karl Briers (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 0 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery March 26,2004 Baltimore, Maryland 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228 21. Signature of Funeral Service Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deal
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy ō Day Year 5 Other (specify) P.O. I been signed by the a should be detached t 9 ☐ Unknowñ Part II. Other significant conditions contributing to death but not resulting 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 3 Probably 4 Unknown 1 Yes ΩNo 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed; 23 certificate 2 🗓 1 Tes or Attending Physician: uneral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one To 2 No Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of ... 1 Natura 28b. Time of ath 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 □ Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No death. after death Director: in by the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 24 hours completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Adical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 2 To the 29b. Signature and title of certifia 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month State 4 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryl	and / Depa	artment rtificate	t of Hea e <i>of De</i>	alth and eath	Mental Hy	giene 2	004	09191
			1. Decedent's Name (First, Middle, Las	it)					2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medic		Edith Adele 3a	ocock					March	15,20		11.05 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Loc	cation of Dea		4c. Cou	inty of Death	11.03 1
			Millenium Nurs		- 1-11-4	Elli	cott	City Under 24 H		Howa		
	Funeral		5. Social Security Number 6. S	DM 2XDF 7. Age (III)	rrs. last birthday) Yrs.	If Under Months		lours Mi	n. (Month, D	ay, Year)	Cour	
	Director	1	156-05-0242   Usual Residence of Decedent	0.3		11			Oct.	9,192	0 New	Jersey
	yland		10a. State 10b. County	10c.	City, Town or Lo	ocation					1	10d. Inside City Limits
	a-fs	ig	MD Howard	d E	llicott	Cit	v					1 □ Yes ¾□ No
	or 28	Sire.	10e. Street and Number			10f. Zip	Code			10g. Citizen	of What Cour	ntry?
	23a	la	3004 North Ride	re Rd. Apt	н 416	210	43 -			USA		
	er de	nue		Attited Forces?	n U.S. 13.	Was Deced If Yes, spec	ent of Hispar ify Cuban, M	nic Origin? ( lexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. F	Race - Americ Black, White,	
36	rs afte	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2	No S	pecify:		Spe	city: wh	ite
5-0036	72 hours after death with the Maryland Instural, or Items 23a or 28a-f show disal Evandrat must be multified at	ed	15. Decedent's Ed		16a. Dece	dent's Usua	l Occupation	1		16b. Kind of	f Business/In-	dustry
215	within 72 ene. than "na he Medi	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	(Give	kind of wor DO NOT us	k done durin e retired)	ng most of w	orking			,
21,	d with	ĕ	12	1	Home	make	r			O	Wn Ho	me
	e filed al Hygi I othar vent, I	Be	17. Father's Name (First, Middle, Last)				18.	Mother's N	ame (First, Middle			
<u> a</u>	Mental Mental arkad c		William Buesing					у Во				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinatinar Item radillard at		19a. Informant's Name/Relationship (7						Rural Route Numb			
	and lealth m 27 her tr		Beverly M. Lipt 20a. Method of Disposition	ai/daughte	2911	Fox	Fire	Cou	rt,Elli	cott (	city,	Md.21042
O.C.	ges 1 t of H Hita or ot		17☑ Burial 2 ☐ Cremation 3 ☐	- 11 01	cernetery, cres	manory or ou	ner place)					
Baltimore	t. Partmen		'4 Donation 5 □ Other (Specify		restla	wn Ma	emori	al Ma	19,20	04-Mai	rriot	tsville,M
Bal	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Licen	0 151	2	2. Name and	d Address of	Facility W.	itzke F	uneral	l Hom	es,Inc.
	40144		23a Part 1 Enter the disease or com	plications that caused the d	5 Do not an	555 T	rwin .	KNol	ls RD.C	olumbi	ia, M	D 21045 Approximate
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final	e cause on each line.	loatii. Do not em		or dying, so	C	ac or respiratory a	1	1,	Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	cent C	ens	ero V	as Ca	un	yecia	100	mines
	Examiner			Nai	sequence of):	ti	1	dia V	lin in culon	DIRC	and	54eurs
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Diseese or injury	b. Due to (or as a con-	SCLVU sequence of):	LLC	Con	7000 1	, -		_	10011
h	uted d ansit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events									
oʻ	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a con	sequence of);		<del></del>					
8760,	ate be execu hysician and the burial-tra	dlcal		d								
9		Ved	IF FEMALE.									
Вох	leath certifica attending pla of for use as t	an/h	230. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pre	egnancy				Date of delive	,
	requires that the death certific een signed by the attending p hould be detached for use as	by Physiclan/Me	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at time ∈		Other (spe		-		'	Month	Day Year
P.O.	d by t	Phy	9 Unknown					D	00- Pid			
	res th	þ	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying ca	iuse given in	Pan I.		robacco use co Yes 2 □ No		ne cause of death? ably 4 □ Unknown
oro	w requir been si should	Completed										
3ec	elaw hasb je 2 st	d L							24a. Was	an 24t psy pmed?	<ul> <li>b. Were autoperior to condeath?</li> </ul>	psy findings available inpletion of cause of
of Vital Records,	ysician: The lavis certificate has director, page 2								1□ Yes	2 1 No	1 Yes	2□ No
ΖΪ	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			0.4		eath (Check only			
oto	Phys r this ral di	2	1 Yes 2 No  27. Manner of Death	1 Linpatient	2 ER/Outpatier 28b. Time o		A 4	Mursing	Home 5 ☐ Res			/)
on	ding th. Afte	to F	1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year	r) Injury	м	Sc. Injury at Work? 1 ☐ Yes	2 □No	100, 200, 100	,,,		i.
Division	Attanding r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	t home, farm, str	eet, factory,	office				mber or Rura	l Route Number,
Ö	al or	Certification:	4  Homicide	building, etc. (Sp.	ecity)				City or To	wn, State)		
	ospita hours mara y fille		29a. Certifier 1 Certifying Ph	sician: To the best of my	knowledge, deat	h occurred a	t the time, d	ate and place	e, and due to the	cause(s) and	manner as st	ated.
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	edical	(Check only 2 Medical Examone)	iner: On the basis of exam and manner stated.	nination and/or in	vestigation,	in my opinioi	n, death occ	curred at the time,	date and place	a, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	)			License nur			29d. Date sign		
			- 56	lum			113	18 49	1	Manc	4 18	Loup
	(0		30. Name and address of person who			Print)	10.	A	Ba 11	1	Marsh	2005p
	Ψ	11	31. Date filed (Month, Day, Year)	ahapalm	341	Cr	wha	TIVE	10411	mily	, compa	0 2 101 )
	Sta Registi		MAR 2 4 200	32 Registrar's Si	M L	. M.						

			For State Registrar	State of	Maryland	d / Depa	artmen <i>tificate</i>	t of H	ealth a Death	and M	lental H	ygien	2004	09192
	Physici /Medic	_	1. Decedent's Name (First, Middle, Las Doris C. Bid	•						]	2. Date of D Month March		oay Year 2004	3. Time of Death 9:47 AM M
	Examin		4a. Facility Name (If not institution, give Genesis Eldercare					Town, or onsvi	Location o	of Death			c. County of Death	
	Funeral Director		5. Social Security Number 6. S 212-22-6985  Usual Residence of Decedent	9x □ M 2 F 7	. Age (In yrs. Ia 92	ast birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	B. Date of E (Month, I July	1. AL	0.01.11	place (State or Foreign intry) 1land
	Maryland a-f show	tor	10a. State 10b. County Maryland Baltimo	re		, Town or Lo towne	cation	*						10d. Inside City Limits  10 Tes 2 □ No
	th with the 23a or 284	Funeral Director	10e. Street and Number 616 Plymouth Road				10f. Zip 212					_	citizen of What Cou ted State	•
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel', or Items 23a or 28e-f show stry injury or other traumatic event, if a Madical Examination must be inclined at ance.	d by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deced Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Date	No	'	Was Deced f Yes, spec l ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	10-	14. Race - Ameri Black, White Specify: Whi	, etc.
21215-(	within 72 h iene. then "natu	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 11th		for 5+)	16a. Deced (Give life. L	kind of wor DO NOT us	k done d e retired)	tion uring most	of worki	ing		Kind of Business/Ir partment	
Maryland 2	2 should be filed and Mental Hygi Is marked other aumatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Frederick H. Bauma	ann		Dazes	CICI				(First, Midd. ad Bake	le, Maide		Store
	1 and 2 should Health and Men em 27 Is marke ther traumatic	3 39	19a. Informant's Name/Relationship (TELVA Eareckson / I			27950	Oakl	ands		le E	Easton,		or Town, State, Zi ryland 21	
Baltimore,	. Pages 1 Iment of H tent: If itel jury or oth		20a. Method of Disposition  1 → Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	")	ate ce	ace of Dispo emetery, cren llawn (	natory or of Cemeto	her place ery	0	3/25	5/2004	Balt	Location - City or T timore, M	arvland
Ball	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Intern	1 m	Wer	ノ 5:	311 E	dmon	dson	Aver.	ue Bal	timo	er Funera ore, Mary	l Homes PA land 21229
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or client shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (or	ine.	lence of):					www.	,	in	Approximate Interval Between Onset and Death
,8760,	The law requires that the death certificate be executed title has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	ras a consequ	ence of):								
.O. Box 6	that the death certific ed by the attending p detached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 ☐ Fetal nt at time of de	death 3	Ectopic pre						23d. Date of deliving Month	ery Day Year
ords, P.	w requires that been signed I should be det	þ	Part II. Other significant conditions o	ontributing to dea	th but not resu	Iting in the ur	iderlying ca	iuse give	n in Part I.			tobacco	use contribute to t	
Il Records,	70	Completed										s an opsy formed? 2 2 N	prior to co death?	opsy findings available impletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe		-	(Check only	1 - 10		
ō	ing After une	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		-	ER/Outpatien 28b. Time of Injury		Bc. Injury Work	4 E Nui	2	ne 5 ∐ Res 28d. Describe		6 □Other (Specification occurred)	(y)
Division	200>	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	f Injury - At hor g, etc. (Specify)	me, farm, stre	et, lactory,	, office		2	28f. Location City or To		and Number or Rura te)	al Route Number,
	To the Hospital or # within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1/2 Certifying Ph (Check only 2 Medical Exen	ysicien: To the b niner: On the bas and manne	is of examinati	vledge, death ion and/or inv	occurred a restigation.	at the time in my op	e, date and inion, deat	d place, a h occurre	and due to the ed at the time	cause( , date ar	s) and manner as s nd place, and due to	tated. o the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier  Ally culcul	o lece	1 ve =	5		License		78	0		ate signed (Month,	
	0		30. Name and addless of person who	completed cause	of death (Item	23a) (Type, I	Print)	Es	2/11	111	R	al V	Ballyen	2/04,
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signati		h	aid 1	· -	, ce	_		U Coope	

			For State Registrer	State of Ma	ryland / De		Health and I	Mental Hygie	•	09193
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last JOHN B37707, 4a. Fecility Name (If not institution, give Balton see Rehals.	street and number)	Vara Con	4b. City, Town,	or Location of Death	2. Date of Death Month March	Day Year  2 / 2 0 4  4c. County of Death  NA	3. Time of Death 7:30 P M
	Funeral Director		5. Social Security Number 6. Se		(In yrs. last birthda	Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, You 3—1—23	9. Birtl	nplace (State or Foreign untry) lorida
	death with the Maryland ims 23a or 28a-f ehow	Director	Md. 10b. County		10c. City, Town or Baltin					10d. Inside City Limits  17 Yes 2 □ No
	th with the 23a or 2		10e. Street and Number  904 St. Dunstans	Rd.		10f. Zip Code	1212	10g.	Citizen of What Co. USA	-
	be filed within 72 hours after death with the Marylan tall Hygiene.  Idea Hygiene.  Idea other than "natural", or itams 23a or 28a-f show event, fra Madical Engineerings Leginalised at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		3. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No		pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify: B1	
Maryland 21215-0036	within 72 hours after ene. then *natural, or its ne Medical Examine	Completed	15. Decedent's Edi (Specify only highest grad	lication (e completed) College (1-4or 5+	) (G	cedent's Usual Occu ive kind of work done b. DO NOT use retire ector of M	during most of wor ed)	king	D. Kind of Business/I	ndustry
nd 2	be filed tal Hygid d other	Be Co	10th grade 17. Father's Name (First, Middle, Last)		,	SCCOL OI 1	18. Mother's Nam	ne (First, Middle, Mar	den Sumame)	
<u> </u>	2 should by and Menta le marked sumatic ev	2	Elijah  19a. Informant's Name/Relationship (T	Bot (pe. Print)		ailing Address (Stree	Marie	ral Route Number, C	Morgan	
Z Z	od 2 115 a 27 Io		Angela B. Hamlet	Daughte	r 26	25 Chester		e., Baltim		21213
ms.	ages 1 and of Heam is Miltern		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I		20b. Place of Dis cemetery, o	sposition (Name of rematory or other pla			c. Location - City or 1	
altiu	permit. Peges 1 Department of H Important: If ite any injury or ot once.		*4 Donation 5 Dother (Specify, 21. Signature of Funeral Service License		Arbutu	S Mem. Pk. 22. Name and Addr			butus, Md timore, M	
	88 5 8		23a. Part1. Enter the disease, or comp	pwa		March F.			North Ave	Approximate
	Physician /Medical Examiner	ı,	snock, or neart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	),	car with				Interval Between Onset and Death
	tificate be executed g physician and as the burial-transit	dical Examiner	Sequentially list conditions, if any, isating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):					
.O. Box (	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	y		23d. Date of delin	very Day Year
ords, P	v requires that been signed b should be deta		Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cause gi	ven in Part I.	23e. Did tobac	co use contribute to	/
al Reco		Completed						24a. Was an autopsy performed 1 Tes 2	prior to c death?	opsy findings available ompletion of cause of
Ž	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	t 2 ER/Outpat	ient 3□ DOA Ot	har	th (Check only one) ome 5 - Residence	e 6 ∏Other (Spec	ifv)
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely lilled in by the funeral director.	Certification; 7	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day		y Wo M 1□		28d. Describe how i	njury occurred	
<u>≥</u>	Hospitel or A 24 hours after Funerel Direc tely lilled in by		4 Homicide determined	building, etc.	(Specify)	street, factory, office	mo date and also	28f. Location (Stree City or Town, S	tate)	
	To the Hospitel within 24 hours a To the Funerel C completely filled	Medical	(Check only 2 Medical Exam	iner: On the basis of e and manner state	examination and/or	investigation, in my	opinion, death occur	red at the time, date	and place, and due	to the cause(s)
)	To the Comp	M	29b. Signature and title of certifies	10		29c. Licen	se number	29d.	Date signed (Month	Day, Year)
_	5x,	l l	30. Name and address of person who co	Bailtim	ath (Item 23a) (Typene Reha	b Extendo	can Ct.	3900 Lie	h Raver	Blud Butta
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 4 2004	32. Registrar	's Signature	K)				4218

State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Charles Joseph 22, Barnickel March 2004 6:30 AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 208 Mason Runn Road Rising Sun If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min. 1 🕱 M 2 🗆 F Yrs. 217-09-8314 Director 85 March 1, 1919 Maryland Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Iniportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or hems 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 Mason Runn Road 21911 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No
If Yes, Give
Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: Š 3 1x Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Insulator of Pipes & Boilers | Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John George Barnickel ဥ Mary (unk) Maygers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen J. Barnickel / Son 208 Mason Runn Road, Rising Sun, Maryland 21911 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillton Service Corp. 3-26-04 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Myocard hours Examiner Due to (or as a consequence of) Examiner signed by the attending physician end d be detached for use as the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has 1 Yes 24tho 1 □ Yes 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury at Work? Certification: 28c. 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00053309 March 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Bow Street Elkton MD Jeffrey TIONGSON Doctor M 31. Date filed (Month) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 09195 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 18, 2004 March 4:10A Thea H. Bowden /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Potomac Arden Courts If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Hours 1 □ M 2 1 F 24, 96 1907 Wisconsin Director 387-05-1230 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State "naturel", or Items 23s or 28s-f ehow idical Examiner must be notified at 1 ☐ Yes 2 TNo Funeral Director Maryland| Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20816 United States 5312 Briley Place 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or item eny injury or other traumatic event, the Medical Exercited 2008. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White δ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Publishing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thorston Hooverson Inga Olson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7913 Turncrest Drive, Potomac, Maryland 20854 Inga B. Frank/Daughter 20b. Place of Disposition (Name of cometery, crematory or other place)
F1eming County Date 20c. Location - City or Town, Stete 20a. Method of Disposition March 23. 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Flemingsburg, KY Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature - Euneral Service Licensee 3Q: M00803 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 Months Inanition /Medical Due to (or as a consequence of): Examiner Advanced Age Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ed bluods 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? 1 Yes 2 No certificate 1 Yes 2 X No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 10ther (Specify) Certification: To 1 Yes 2 No hours after death. uneral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide To the Hospital within 24 hours a To the Funeral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D D39456 March 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue, #1400, Chevy Chase, Maryland 20815 Lila T. McConnell, M.D. 31. Date filed (Month, Day, Year) MAR 2 4 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

9:00

JOAN BOYER

ORIGINAL

		For State Registrar			nd / Depa		lealth and	Mental Hy	giene <sub>Reg. No.</sub> 200	
Physici /Medio	al	Decedent's Name (First, Middle,      Doris Jean Be     Aa. Fecility Name (If not institution.	ender	mhasl		Ab Cibi Tourn	or Location of Dea	2. Date of De Month MARCH	Day Yee  15 200  4c. County of De	4 7:09 p M
Examin Funeral Director	er	St. Mary's H		7. Age (in yrs.	last birthday) 72 Yrs.		rdtown	S. R Date of Rin	St. Ma	
he Maryland 28a-f show	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         St. Ma:           10e. Street and Number	cy's		ty, Town or Lo	eville			40- Citizen of When	10d. Inside City Limits 1 ☐ Yes 2 ▼No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show shy injury or other treumatic event, tre Madical Examinar must be notified at once.	by Funerai Dir	37404 Heath Ct  11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Dec	2∏No ve		10f. Zip Code  20659  Was Decedent of If Yes, specify Cub  1□ Yes 2√2 No	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	USA  14. Race - A Black, W  Specify: T	merican Indian, hite, etc
Maryland 21215-0036 vd 2 should be filed within 72 hours aft th and Mantal Hygiene. 27 is marked other then "natural, or treumatic event, the Madical Exami	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (	1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire eacher	during most of w		16b. Kind of Busine Public S Maiden Sumame)	
Maryland 27 d 2 should be filed w th and Mental Hygie 7 is marked other t treumatic event, to	To Be	Hubert Stahl  19a Informant's Name/Relationshi Russell Bender/1	p (Type, Print)				Sadie and Number or H	Loving	er, City or Town, State	
Baltimore, M bernit. Pages 1 and 5 Department of Heelth mportent: If item 27 is ny injury or other tre		20a. Method of Disposition 1	3 □Removal from ocify)	Carac	Place of Disponentery, cremetery, cremetery, cremetery	sition (Name of matory or other pla	ry Marc	Date ch 19, 20	20c. Location - City 004 Suitla -Echols F	or Town, State
Balti permit. Depertm Importe any inju		21. Signatore of Funeral Service Li  23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that	caused the dea	. I	2.0. Box	128, Cha	erlotte H	Mall, MD 20	Approximate Interval Between
Physician /Medical Examiner  which and the pringing of the pringing of the pringing of the pringing of the pringing of the pringing of the pringing of the pringing of the pringing of the pringing of the principle of the princip	lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec	quence of):	: Arr	ythm ia	ia		one day
ds, P.O. Box 687 ires that the death certificate signed by the attending phys d be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live I	tcome of pregn birth 2 Feta nant at time of (	al death 3	Ectopic pregnand Other (specify)	у		23d. Date of Month	delivery Day Year
ecords, P. law requires that as been signed b 2 should be deta	Completed by Ph	Part II. Other significant condition	s contributing to d	leath but not res	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	Yes 2, 2√No 3 □	o to the cause of death?  Probably 4Unknown  autopsy findings available to completion of cause of
f Vital Roysicien: The is certificate hidrector, page	To Be Com	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1	Thpatient 2	] ER/Outpatier	nt 3 DOA Ot	her	perfo 1 ☐ Yes eath (Check only o	ormed? death 2DNo 1□Y	? es 2 No
Division of Vital Records, P.O. Box 687  To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Certification:	27. Manner of Death  1 Autural 5 Pending 2 Accident investigs 3 Suicide 6 Could not determine	ot be 28e. Place	of Injury oth, Day Year) e of Injury - At h ling, etc. (Speci	28b. Time o Injury	Wo	Yes 2□No		how injury occurred  Street and Number or wn, State)	Rural Route Number,
To the Hospitel within 24 hours a To the Funerel i	Medical (	29a. Certifier 1. Certifying (Check only one) 2 Medical E	xeminer: On the b	e best of my kn basis of examination stated.	owledge, deat ation and/or in	vestigation, in my	ime, date and pla opinion, death oc se number	ce, and due to the curred at the time,	cause(s) and manner date and place, and of 29d. Date signed (Mo	lue to the cause(s)
14 8 B			ho completed cau		m 23a) (Type,	D	5434	-6	3/16	
St. Regist	ate rar	CHANDRA SAJJA 31. Date filed (Month, Day, Year) MAR 2	32. F	SSOC HOI Registrar's Sign	ature	MD. 20	636			

DHMH 17 Rev 1/2001

DORIS BENDER

(No			For State Amend Item :	State of N 23a PtI per Dr.	Maryland / De ,G829,03/30	partment of H	lealth a Death	nd Mental	Hygien	. 2004	กฐเจล
¥.	* *.	Ģ.	Decedent's Name (First, Mid.						of Death	ay Year	3. Time of Death
8.	Physicia	100	JAMES	CURRY				March			756 A M
	/Medic Examin	- 3	4a. Facility Name (If not instituti	on, give street and number	er)	4b. City, Town, or	r Location of	Death	4	c. County of Death	
*			JOHNS HOPKI	NE BAYUL	ew	BALTIN	10121			BACTIM	LORE
	Funeral Director		5. Social Security Number 166–28–1005		Age (In yrs. last birthda 66 Yrs.	Months Davs	If Under 2 Hours	Min. (Mon	of Birth oth, Day, Yea 5, 193	9. Birth Cou 7	place (State or Foreign intry) GA
_	p ,		Usual Residence of Decedent	64.4	10c. City, Town or	Location					10d. Inside City Limits
	Maryla f shov	tor	NJ 10a. State 10b. Coun	Burlington	_	etampton					1 XYes 2 No
	with the a or 28e-	Director	10e. Street and Number 5 East Maple Tre	e Drive		10f. Zip Code	08060	·	10g. C	itizen of What Cou	intry?
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: if item 27 is marked other than "natural", or Items 23a or 28e-f show important: if item 27 is marked other than "natural", or Items 23a or 28e-f show amy injury or other treumatic event, the Medical Evaluation of the conflict and once.	Funeral	11. Marital Status 1 ☐ Never Married 2 ★★	12. Was Decede Armed Force 1 XX es 21 If Yes, Give		3. Was Decedent of H If Yes, specify Cuba  1 Yes XX No	lispanic Orig an, Mexican, Specify:	in? (Specify Yes Puerto Rican, e	or No-	14. Race - Ameri Black, White	
Maryland 21215-0036	72 hours natural', lical Exa	ted by	3 Widowed 4 Divorce	ed Year or Date ent's Education hest grade completed)	16a De	cedent's Usual Occupive kind of work done	ation	of working	16b.	Kind of Business/Ir	
121	within 7 ene. than "r	Completed	Elementary/Secondary (0-12		life	<ul> <li>DO NOT use retired</li> <li>Lieutenant</li> </ul>	d)			US	Army
nd 2	be filed ntal Hygic ad other	Be	17. Father's Name (First, Middle Alton Glover					r's Name (First, M			
<u>  3</u>	should ind Men ind marke	ဥ	19a. Informant's Name/Relatio	nship (Type, Print)	19b. M	ailing Address (Street				or Town, State, Zi	ip Code)
	and 2 s saith an n 27 is i		Carlton Curry /		123	Westminster		Mount La	urel NJ	08054	
altimore,	Pages 1, nent of He ant: If Itan ury or oth		20a. Method of Disposition  1  Burial 2  Crematio  4  Donation 5  Other		Memorial		arch 15		Hlytl	Location · City or T	
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service	Calicensee Victor	P. Doda	22. Name and Addre Charles L. 1501 East	ss of Facility Stev Fort	ens Fune Avenue,	eral Ho Baltin	ome, Inc. more MD 2	21230
	Physician		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition	ist only one cause on eac	h line.				atory arrest,		Approximate Interval Between Onset and Death
10	/Medical Examiner	Iner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequence of):  as a consequence of):	-wsuffi ci	ency				
,092	ficate be executed g physician and as the burial-transit	Ical Examine	Cause (Disease or injury that initiated events that initiated events resulting in death) Last	U	iple Myeloma as a consequence of):						
.O. Box 68	death certi e attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ∏Fetal death at at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у			23d. Date of delik Month	very Day Year
<u> </u>	The law requires that the de ate has been signed by the a bage 2 should be detached to	þ	Part II. Other significant cond		th but not resulting in th			236	e. Did tobacci	_	the cause of death?
Vital Records,	The law requir ate has been s page 2 should	Completed	chronic inf DiABETES	- Commitory	deniyeli	nating pol	y weer	· / _	a. Was an autopsy performed?	prior to c death?	topsy findings available ompletion of cause of
ita		0	25. Was case referred to med	ical		7 70/2	26. Place	of Death (Check	<del>.</del>		
		0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inc	atient 2 ER/Outpa	atient 3 DOA Ott	ner: 4 🗆 Nu	rsing Home 5[	Residence	6 Other (Spec	uty)
on of	ling Phys After this iuneral di	lon: T	27. Manner of Death  1 Natural 5 Per	iding	Injury 28b. Tim Day Year) Inju	ry Wo	ryat rk? ]Yes 2 □1		scribe how in	jury occurred	
Division	or Attending after death. Director: After in by the funer	Certification:	3 Suicide 6 □ Cou		f Injury · At home, farm , etc. <i>(Specify)</i>			28f. Loc	ation (Street or Town, Sta	and Number or Ru ale)	ral Route Number,
J	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edical Ce	29a. Certifier Certifier (Check only one) Certifier	fying Physician: To the b cal Examiner: On the bas and manne	est of my knowledge, d is of examination and/or stated.	leath occurred at the to or investigation, in my	me, date an opinion, dea	d place, and due th occurred at the	to the cause e time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	omple	Me	29b. Signature and title of cert	trfier		29c. Licen	sa number		29d. [	Date signed (Month	n, Day, Year)
	->-0		Dean &	Pacie M	.0-	230	02		Marc	69 20	04
	)/\		30. Name and address of pers	ALILI	JOHN		INS P	bAyvie	w		
	St Regist	ate rar	31. Date filed (MATA Pry. 26	4 2004 32 Ae	gistrar's Signature	Soul !					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 0 0 1- State RegistrarAMEND ITEM #1&28f PER PHY G8293/24/Orathicate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:00 pm BETTY JEAN CLARK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner IDF LIONS MANOR Cumberland, MDZISZZ Hllegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F Days Hours -30-7571 Yrs. Marylánd Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "netural", or Items 23e or 28e-f show the Medical Examination must be notified at MD 1 → Yes 2 No Allegany **Funeral Director** Western port 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street HAMMOND 21562 USA filed withIn 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White δ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 telephone operator telecommunications permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Importent: If Item 27 is marked other any injury or other treumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adrian Simpson Rankin Annie May Cropp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Hardesty/daughter 103 Battlefield Winchester, VA 22602 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wards 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 or complication Enter the disease, or complications the or heart failure. List only one cause o Approximate Interval Between caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of) Examiner no Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner ng physician and as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) P.O. I 1 ☐ Yes 2 ₺ No 9☐ Unknown 9 ☐ Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 🗹 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 6 Pother (Specify) DIA17 SIS Unit 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Injury 5 Pendina 1 Matural 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 T Homicide To the Hospital within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year) MAR 2 4 2004

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year) MARCH 8

	1	For State Registrar	State of Mar	yland / Depa <i>Ce</i>	artment of F rtificate of			eg. No. 200	4 09201
Physician /Medica Examine	1	Decedent's Name (First, Middle, L     Alla Louise     As Facility Name (If not institution, gi	Carnduff Jo	hnson	4b. City, Town, o	r Location of Death	2. Date of Dea Month March	Day Yes	1:30 p <sup>N</sup>
Funeral		Victoria Home		'In yrs. last birthday)	Gaithers	sburg		Montg	omery
Director		577-26-0306 Usual Residence of Decedent	1□M 2 <b>X</b> XF 8	6 Yrs.	Months Days	Hours Min.	Dec. 1,	Year)	Birthplace (State or Foreig Country) ashington, I
Ba-f show		MD 10b. County MD Montgo	1	Bethes	da				10d. Inside City Limits  1 → Yes 2 → No
th with the 23a or 2	2	10e. Street and Number 8212 Fenway Roa	d		10f. Zip Code 20817		1	og. Citizen of What United	•
ges 1 and 2 should be filed within 72 hours after death with the Maryland in of Health and Mentai Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Macical Examinar must be natified at To Re Commissed by Europa Director.	Dy ruilei	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hilf Yes, specify Cubin 1 ☐ Yes 2 ▼ No	lispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No- Pican, etc.)	Black, W	merican Indian, hite, etc. White
ad within 72 hours afligione. er then "naturel", or it the Musical Example.	naidille	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired memaker	ation during most of wor d)	king	16b. Kind of Busine	ss/Industry
d 2 should be filed within ith and Mental Hygiene.  77 is marked other than ", traumatic event, the M  To Re Commit	מ	17. Father's Name (First, Middle, Las Arthur Willa	t)			18. Mother's Nam	ne (First, Middle, M Mary R	Maiden Sumame) hodes	
i and 2 sho lealth and I im 27 is mu her trauma		19a. Informant's Name/Relationship Margie Orrick/Da		8212	Fenway R		hesda, M		
t. Pa rtmer rtent njury		20a. Method of Disposition  1 □ Burial 2 □ Memation 3 (  4 □ Donation □ □ Other (Spec	ify)	Chesapea	natory or other plac	ory 3/2	2/04	Beltsvil	
permi Depa Impo any is	1	Jani o	1, Holli	end	Simple Tr 1040 Rock	ibute Fu	ke Rocky	d Cremati ille, MD	On Center 20852 Approximate
Physician /Medical Examiner		23a Port1. Enter the disease, or con- sock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Alzheir	mers Demen					Interval Between Onset and Death Years
		Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or might) that initiated events	b. Due to (or as a c	consequence of):					
ysicis	Calch	resulting in death) Last	Due to (or as a o	consequence of):					
attendin for use	iyalcıdırıme	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2   4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of a	delivery Day Year
wrequires that the deben signed by the should be detached larged by the larged by Physic	2	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.			to the cause of death?  Probably *XXUnknown
The law requires t ale has been signe page 2 should be completed by	naldillon						24a. Was an autops perform	y prior t ned? death	autopsy findings available o completion of cause of ? es 2 \( \) No
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerei Director: After this certificate has completely filled in by the funeral director, page 2	2	25. Was case referred to medical examiner?  1  Yes 2 \( \) No  27. Manner of Death  1 \( \) Natural 5  Pending  2 \( \) Accident investigation	Hospital: 1 ☐ Inpatient  28a. Date of Injury (Month, Day Y		28c. Injur Wor	er: 4 🗆 Nursing H	th (Check only one one 5 Reside 28d. Describe ho	nce Other (S	pecify) Group Home
To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the tuners Mardical Cortification.	20111120	3 Suicide 6 Could not 4 Homicide determined	De og Diese of leive	- At home, farm, str (Specify)	eet, factory, office		28f. Location (Sti City or Town		Rural Route Number,
the Hospit thin 24 hour o the Funer mpletely fills	בחונשו	(Check only 2 Medicel Exa	hysicien: To the best of a miner: On the basis of ex and manner state	xamination and/or in	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
To T Com	A	29b. Signature and title of certifier	laure		29c. Licens	nu <i>m</i> ber 1391		March 22,	
1 =		30. Name and address of person who Dr. S. Abulfa:	1 1 1	th (Item 23a) (Type, Shady Gro		Suita 10	O D = 1	.111 - MD	20850

		Ame	end Item 26 per Verb., G829, 03/24/04dhb Certifi	ment of He	ealth and Me Death	ntal Hygie	ene 1. No. 2 A A I	00001
			Decedent's Name (First, Middle, Last)			Dete of Deeth	C 0 0 1	3. Time of Death
	Physicia		Angelo F. Cammarata			Month 03	Day Year 10 2004	12:50 AM
	/Medic Examin	_	4e Fecility Neme (If not institution, give street and number)	4t	o. City, Town, or Loca		4c. County of Deet	
		Ŭ.	6L Brook Farm Court		Perry Hal	1	Baltimon	re
T	Funeral		Mo	Under 1 Year onths Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Dey, Y	(ear) 9. Birt	hplace (Stete or Foreign untry)
4	Director		219–32–1661 <sup>1</sup> ♥ M 2□ F 67 Yrs. MG			03/23/1	936 Ma	ryland
	and with	-	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on				10d. Inside City Limits
	Marylar fahow	ğ	MD Baltimore Perry Hali	1				1 ☐ Yes 2 📉 No
	th the Mar or 28a-fal	Director	10e. Street end Number 1	Of. Zip Code		100	g. Citizen of What Co	untry?
	23a o		6L Brook Farm Court	21128			U.S.A.	
	dea	Funeral	11. Maritel Status 12. Was Decedent Ever in U,S. 13. Was Armed Forces? 13. Was	Decedent of His	spenic Origin? (Specif n, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, White	
20	or it	ð 고	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No — If Yes, Give 1 ☐ Y	_	Specify:		Specify:	
8	72 hours after death with the Maryland natural', or fleme 23a or 28a-f show dical Examiner must be notified at		3 Widowed 4 Divorced Year or Detes:	's Usual Occupat	tion	16	WD b. Kind of Business/	ite
7	in 72	Completed	(Specify only highest grede completed) (Give kind life. DO N	of work done du NOT use retired)	urina most of workina		D. King of Eganless	industry
212	iane.	Eo	Elementary/Secondary (0-12) College (1-4or 5+) 10 Music	ian			Self-Empl	oved
b	be filed stal Hygi of other event, t	Bec	17. Father's Neme (First, Middle, Last)		18. Mother's Name (F	First, Middle, Ma		
<u>Ja</u>	should be nd Mantal marked o	2	Frank P. Cammarata		Ernestin	a Pergo	la	
Maryland 21215-0020	and s m		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailing Ad	ddress (Street e	nd Number or Rurel F	Route Number, (	City or Town, State, 2	(ip Code)
	end 127 er tr	-			Court - Pe		11, MD 2	21128
Baltimore,	of July		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	ny or other place	)			
Ħ	t. Pag rtment rtant: I		4 Donation 5 Other (Specify) Gardens of	Faith C ame and Address			Baltimore,	
Bal	permit. Pag Department Important: I any Injury c		1000					al Home, P.A.
		_			ir Road - 1			21087 Approximate
		Н	23a. Pert1. Enter the disease, of complications that caused the death. Do not enter th shock, or heart failure. List only one cause on each line.	e mode or dying	, such as cardiac or r	espiratory erres	i,	Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final				1	600
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Lung Concretion  Due to (or as a consequent)	ice of).			1	0/30
		ner	Sub to (of us u consequent	55 517.				
	ate be axecuted hysicien enc tha buriel-transit	Examiner	Sequentially list conditions, if eny, leading to immediate	ce of):				
Ő,	ate be axe shysicien e tha buriel-		if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c					
8760,		dicai	thet initieted events resulting in deeth) Lest Due to (or as a consequence	ce of):			1	
9	aath certific attending p for use es	Me	d					
Box	atten atten for u	cian				an Bid. 1		A the same of deaths
P.O.	as that tha dai igned by the a be datached f	Physician/M	Part II. Other algnificant conditions contributing to deeth but not resulting in the under	lying cause give	n in Part I.	230. Did tob		to the cause of death?
σ,	s that ned b a data	<u>&gt;</u>				LANGE OF		
Division of Vital Records,	Tha law raquiras that tha daath certific Ite has been signed by the attending p page 2 should be datached for use es	Completed by				24a. Was an		Were autopsy findings
ပ္ထ	aw raqu is been 2 shoul	piet			-	ponomi		completion of cause of death?
æ	Tha la	EO				. T□Yes	21.00	I□Yes 2□No
ita		Be	25. Was case referred to medical examiner?	19707	26. Place of Death /	Check only one)		
<u>&gt;</u>	S 50	P L	1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient 3	3□ DOA Othe	4 LI Nursing nome		ce 6 □Other (Spe	cify)
Ē	ding Ph h. After th funeral	ö	27. Manner of Deeth  1 □ Natural 5 □ Pending  28e. Date of Injury (Month, Dey Year)  28b. Time of Injury	28c. Injury Work' M 1 ☐ Y	et 28/ ? res 2 No	d. Describe how	r injury occurred	
Sic	death tor: /	cat	2 ☐ Accident  3 ☐ Suicide 6 ☐ Could not be			. Location /Stre	et and Number or Ru	ıral Route Number.
Ξ	or At aftar Direc	eri	4 Homicide determined building, etc. (Specify)	ractory, cirico		City or Town,	State)	
_	Hospital 24 hours Funeral stely filled	Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	curred at the time	e, date and place, and	d due to the ceu	se(s) and manner as	steted.
	n 24 h		(Check only one) Medical Examiner: On the basis of examinetion end/or investioned and menner stated.	gation, in my op	inion, death occurred	et the time, date	e and place, end due	to the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attended the Completely filled in by the fur	Σ	29b. Signature end title of centifier	29c. License	number		d. Date signed (Monta	
T			1///	LDS	1865	0	13, 10,0	4
	(4)	Ī	30. Name end eddress of person who completed cause of death (Item 23e) (Type, Prin	1)	Street (	2	1 1	012=:
		2	Martin Edelman 22.5.  31. Dete filed (Month, Day, Year)  32. Registrar's Signeture	Orienz	JIMET !	JaiTiM	vie MD	21501
1	Sta Registr	25	MAR 2 4 2004					
	3		and the state of t					

DHMH 16 Rev 6/95

		•	For State Registrar	State of M	laryland		artment of F		nd Mental Hy	giene Reg. No.	2001	00000
			Decedent's Name (First, Middle, La	ist)					2. Date of De		6000	3. Time of Death
	Physici			•					Month	Day 1.0		14
	/Medic		Warren E. Coop  4a. Fecility Name (If not institution, gin		r)		4b. City, Town, or	r Location of I	March	18 4c.	2004 County of Deeth	6:14 A. <sup>m</sup>
	Examin	er	V		,							
			2104 Drummond RD 5. Social Security Number 6.5	Sex 7. A	ige (In yrs. la	ast birthday)	Catons If Under 1 Year		Hrs. 8. Date of Bir	th	Baltimo 9. Birth	place (State or Foreign
П	Funeral Director			1∰M 2□F	80	Yrs.	Months Days	Hours	Min. (Month, Da 10/01/1	iy, Year)	MD	intry)
		ł	Usual Residence of Decedent		- 00				10/01/	1923	<u> </u>	
	ylanc now		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mar	tō	MD Baltim	ore		Cato	onsville					1 ☐ Yes 2 X No
	r 282	rec	10e. Street and Number	OIC		oac	10f. Zip Code			10g. Citi	zen of What Cou	intry?
	3a o	9	2104 Drummond RD				2	1228		US	. A	
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28a-f show the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Deceden		3. 13. 1			n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Ameri	
(O	or the	3	1 ☐ Never Married 2 ☑ Married	Armed Forces					Puerto Hican, etc.)		Black, White,	, etc.
č	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates	WWII		1 ☐ Yes 2 🛣 No	Specify:			Specify:	White
Ō	2 ho	Completed	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	ation	4	16b. Ki	nd of Business/Ir	
7	hin 7	ple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4o	(5+)	life.	kind of work done of DO NOT use retired	during most o d)	r working			
2	filed withi Hygiene. other then	М	12	1		Te	chnician			C 8	P Tele	phone
פ	be file ital Hy id othe event.	Be (	17. Father's Name (First, Middle, Las	)				18. Mother's	Name (First, Middle,	, Maiden	Sumame)	
<u>a</u>	Alenta Alenta rked tice	ToE	Walter E. Cooper					Mar	y Christir	ne Ba	ker	
Maryland 21215-0036	should and Men marke umatic		19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	ng Address (Street		or Rural Route Numb			p Code)
_	and 2 salth a n 27 is		Irene Cooper/Wif	е		2104	Drummond	RD	Baltimore,	MD	21228	
ē,	s 1 a f Hea itam othe		20a. Method of Disposition	_	1 00	ace of Dispo	sition (Name of natory or other place		Date		cation - City or T	own, State
Ē	Pages nent of int: if it iry or o		1 Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci		9		ark Cemet		/22/2004	Da1	timore,	MD
Baltimore,			21. Signature of Fuseral Service Ve		Lou							
ã	permit. Departr Imports any injt		Volum Go	Can A		St	erling A	shton	Schwab Fur e. Baltim	ieral	Home,	Inc.
			23a Part. Enter the disease, or con	pplications that cause	ed the death.						FID ZIZ.	Approximate
9			shock, or heart failure. List only	one cause on each	line.		01	Sil				Interval Between Onset and Death
В	Physician /Medical		disease or condition resulting in death)	a. Cor	our	uj c	Mear	une	an			4
n si	Examiner			Due to (or a	s a consequ	errice of):	M. n.	1-1	velins.			41
		20	Sequentially list conditions,	b. Cll	s conseque	ance of):	11cm	yes	iiii)			9'
W	be ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 0	3 - 00113640	erice or).		100				6
	and I-trar	хап	that initiated events resulting in death) Last	c. Due to (or a	s a consequ	ence of):						
60,	be e) cian buria	E		200 (0 (0)		3.103 31).						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		_ d								
9 X	n certific anding p use as	Me	IF FEMALE:	22c If you outcom	a of program	201						
Box	eath certif attending for use a	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Fetal	death 3	Ectopic pregnancy			101	23d. Date of deliv Month	ery Day Year
 	e de the a	/sic	1 Yes 2 No	4□Pregnant 9□ Unknown	at time of de	ath 5∟	Other (specify)					
P.O.	that the de led by the a detached t	by Physician/Me	Part II. Other significant conditions	contribution to doubt	but not room	Mina ia tha	adachia a cassas ass	an in Cont I	22a Did	abassa u	na anatsibuta ta t	the cause of death?
s,	res tha igned be del	b	O 12 Lille	biele		iting in the th	ilderlying cause giv	en in Fanti.	10			
ord	w requir been si should i	ted		mu			d lov 1)			Yes 2[	□No 3□Prol	bably 4 🗹 Unknown
Division of Vital Records,	e iaw I has bu je 2 sh	Completed							24a. Was		24b. Were auto	opsy findings available ompletion of cause of
<u>س</u>		Con							perfo	rmed? 2 No	death?	
ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					26. Place of	Death (Check only of	one)		
<b>&gt;</b>	Attending Physician: r death. ector: After this certific by the funeral director.	To	1 Yes 2 No	Hospital: 1 🗆 Inpai	tient 2 E	R/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursi	ing Home 5 Hesi	dence (	S □Other (Specia	fy)
0	lg Pt ter th		27. Manner of Death  1. ✓ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury av Year)	28b. Time of Injury	28c. Injun Wor	y at	28d. Describe I	how injur	y occurred	
Ö	ath. or: Af	atic	2 Accident investigation	n		,,		Yes 2 □ No	4			
<u>Vis</u>	er de ecto	tific	3 Suicide 6 Could not to determined	289. Place of I	njury - At hor	me, farm, str	eet, factory, office		28f. Location (3 City or Tox	Street an	d Number or Rura	al Route Number,
ā	s afte	Certification:		Jonania, i	(,	,			0.1, 0.10	m, biaio,	,	
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral		29a. Certifier 1 Certifying P	hysician: To the bes	t of my know	vledge, death	occurred at the tin	ne, date and p	place, and due to the	cause(s)	and manner as s	stated.
	n 24 he Fi	Medical	one)	and manner	stated.	on and/or in	vestigation, in my o	pinion, death	occurred at the time,	date and	place, and due to	o the cause(s)
	To the within to the company	Σ	29b. Signature and title of certifier	1.11/15	M		29c. Licensi	e number	3.	29d. Dat	e signed (Month,	Dey, Year)
			> Alejanelin	marju	/_		200	8180		3-	14-0	4
	. 1		30. Name and andress of person who	completed cause, of	death (Item	23a) (Type.	Print)	, ,	010	11	and -	2/55 1/2
	10			Elin M	D. 4	105	treclin	ile	ild. Bai	llen	nove 2	1660
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signati	ure						
	Registr	ar	MAR 2 4 200	A Steeler	, B	Long	E.					

		1	For State Registrar	State of Ma		Department Certificate	of Health and of Death		iene 2004	09203
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Las	"Christi	ran			2. Date of Dea Month	th Day Year	3. Time of Death
	Examin Funeral	er	4a. Facility Name (If not institution, give Unit Ve/Sity of Mix 5. Social Security Number 6. Security Number 11	yland	(In yrs. last bir	Ba	Town, or Location of Dea (Hmere, Me 1 Year If Under 24 Hr Days Hours Mir	S. 8. Date of Birth	4c. County of Death  Sci (Him co	
	Director		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location		DILL 21	1 1973	10d. Inside City Limits
	Maryla f sho	ō	MD NA			BALTIMORE				1X Yes 2 □ No
	r 28a-	Director	10e. Street and Number			10f. Zip (	Code	1	l0g. Citizen of What Co	untry?
	th with		3038 PRESSIMA				21216		USA	Zana ta di an
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or itama 23a or 28a-f show important: if item 27 is marked other then "natural", or itama 23a or 28a-f show any injury or other traumatic event, the Modical Examinar motal be notified at ance.	by Funerai	11. Marital Status  1 Xever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 200 N If Yes, Give Year or Dates:		13. Was Decede If Yes, speci	ent of Hispanic Origin? ( Ify Cuban, Mexican, Pue	Specify Yes of No- into Rican, etc.)	Specify: AF	
21215-0036	vithin 72 horne. ne. hen "natur	Completed	15. Decedent's Ed (Specify only highest gra	de completed) College (1-4or 5-			k done during most of w e retired)	orking	16b. Kind of Business/	
d 2	filed v Hygie other t	e Co	12th 17. Father's Name (First, Middle, Last)	0		TECHNIC		ame (First, Middle,	HOSPIT Maiden Sumame)	AL
lan	Ald be rid be riked o	To B	WILFORD ECH	RISTIAN				CHARLOTTE	M. SPEIGHT	
Maryland	2 should and N is mail		19a. Informant's Name/Relationship (7		19b	o, Mailing Address	(Street and Number or F			vree (A
e, Z	1 and 1ealth em 27 ther tr		CHARLOTTE M. SPEIG	HT (MOTHER)		f Disposition (Nam	ne of	BALTIMORE,	MARYLAND 212 20c. Location - City or	
nor	ages ant of l ht: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify		1	ry, crematory or ot CREMATORY	her place)     3/27	/04	CATONSVILLE	MD
Baltimore,	permit. P Departme Importan eny injur		21. Signature of Funeral Service Licen	_	//_	22. Name and	d Address of Facility W	YLIE FUNERA	L HOME PA	, 110
	Pnysician /Medical Examiner	ler	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (or as a	the death. Do ne.	not enter the mode of):	N. GILMOR STRE e of dying, such as cardi	ET BALTIMO	RE, MD 21217	Approximate Interval Between Onset and Death 3 munths
,0928	cate be executed physician and the burial-transit	ai Examin	cause. Enter Underfying Cause (Disease or icijury that initiated events resulting in death) Last	C. Due to (or as a	a consequence	of):				
687	g physias the	ledicai								
.O. Box	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	n 3 ☐ Ectopic pri 5 ☐ Other (sp.			23d. Date of de Month	livery Day Year
<u>α</u>	w requires that the bear signed by should be detact	ğ	Part II. Other significant conditions of	contributing to death be	ut not resulting	in the underlying c	ause given in Part I.		obacco use contribute to	o the cause of death? robably 4 @enknown
al Records,		Completed						1 Yes	med? prior to death? 2 \( \text{No} \) 1 \( \text{L2 Yes} \)	utopsy findings available completion of cause of 2 No
of Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/O	utpatient 3 DC	Other	eath (Check only o	ne) lence 6 □Other (Spe	cify)
	fing After fune	-	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inju (Month, Date	ry 28b.		8c. Injury at Work? 1 Yes 2 No		now injury occurred	
Division	A D D S	Certification:	3 Suicide 6 Could not be determined		ury - At home, f c. (Specify)	farm, street, factory	, office	28f. Location (5 City or Tox	Street and Number or R vn. State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best miner: On the basis of and manner sta	f examination a	ge, death occurred nd/or investigation	at the time, date and pla , in my opinion, death or	ice, and due to the c curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the Complex	Me	29b. Signature and title of certifier	1	MB	290	P1765	0	29d. Date signed (Mon	th, Day, Year)
	B		30. Name and address of person who		Such	(Type, Print) Greene	St. Balton	ore MD	2/2/0	
	St Regis	ate	31. Date filed (Month, Day, Year) MAR 2 4 2004		ar's Signature	Spork	St. Baltim	,		

		1	For State Registrar	State of Ma	ryland / I	Department of Certificate of		Reg	ne 2001	+ 09204
AS.	Physicia		1. Decedent's Name (First, Middle		4VES			2. Date of Death Month MARCH	Day Year	3. Time of Death
100	/Medic Examin		4a. Facility Name (If not institution	, give street and number)		4b. City, Town,	or Location of Deat	h	4c. County of De	oth // /
	Lxamiin	5.	NUNTHWEST	HOSPITAL	CON	Ten Ri	NOA (15th	DWN	BAC	TIMORE
Apalityas	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last bi	irthday) If Under 1 Yea  Months Day  Yrs.		(Month, Day, Y	<sup>(ear)</sup> 20 9. Bi	rthplace (State or Foreign ountry) MD
à.	Director		217-03-9345 Usual Residence of Decedent	XX	84	113.		01 22	20	MD
	land ow	-	10a. State 10b. County		10c. City, Tov	vn or Location				10d. Inside City Limits
	Mary If sh	tor	MD Hai	ford	Eđg	ewood				1 ☐ Yes %(TXNo
	or 28s	lrec	10e. Street and Number			10f. Zip Code		100	. Citizen of What C	
	23a	rai	411 Bauers Di			_	1040	Ingoin Van or No	U.S.A.	
ဖွ	be fited within 72 hours after death with the Maryland stal Hyglene. Ind other then "natural", or items 23a or 28a-f show no other then "natural", or items 23a or 28a-f show event, the Medical Exam are must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give		13. Was Decedent of If Yes, specify Cu		to Rican, etc.)	Black, Wh	ite, etc.
003	ural',	d b	3 XWidowed 4 ☐ Divorced	Year or Dates:		a. Decedent's Usual Occ	upation	16	b. Kind of Busines	3lack
21215-0036	n 72 h	Completed by	15. Deceden (Specify only highes	st grade completed)		(Give kind of work dor life. DO NOT use reti	ne during most of wo red)	rking	D. 14110 01 Duanies	
12	within lene. than	mo	Elementary/Secondary (0-12)  2th grade	College (1-4or 5	+)	Merchant	Seaman	Me	erchant	Marine
b	il Hygi other	0	17. Father's Name (First, Middle,					me (First, Middle, Ma	uiden Sumame)	
<u>Ilar</u>	should be ind Mental inarked of umatic ev	To B	Willie Davis				Ida			
Maryland	2 sho and and 18 m		19a. Informant's Name/Relations			b. Mailing Address (Stre				21p Code) 1040
	s 1 and 2 f Health item 27 other tr		Christine Gi 20a. Method of Disposition	lmore-Niece	20b, Place	1 Bauers of Disposition (Name of	1		oc. Location - City of	
ŏ	of of		1 W Burial 2 ☐ Cremation		cemet	ery, crematory or other p	1	2/26/04	Orași ara a 1	willa Md
Baltimore,			*4 ☐ Donation 5 ☐ Other (S		Garri	son Fores	ress of Facility H West	3/26/04	owings.	illis, Mu
Ba	permit. Departr Importa any inji	13	( Xala	March		March F	'/H West abash Ave	e, Balti	more Md	21215
	N. S.		23a. Part1. Egyer the disease, or	complications that caused only one cause on each lin	the death. Do	o not enter the mode of o	lying, such as cardia	c or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- /	VIE	RENTIL	FA Cu	RE		Onset and Death
	/Medical		resulting in death)	Due to (or as			1			
4	Examiner		Sequentially list conditions,	D	#300/	myolys.	2			
950	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	- Detui	math			
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	C. Due to (or as	a consequenc	e of):	114/001			
760,	siciar siciar	cai		d						
68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit									
Вох	th cer endin r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth					23d. Date of o	elivery Day Year
	e dea he att	sicl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death	5 ☐ Other (specify,	)			
P.0	hat th od by detach	Phy	Part II. Other significant conditi	ons contributing to death b	ut not resulting	g in the underlying cause	given in Part I.	23e. Did toba	acco use contribută	to the cause of death?
Records,	w requires that been signed b should be deta	d by	SEASIS	Elesta Dinne	DET	TCICE CO	Lites .	1 ☐ Yes	21 <b>0 №</b> 0 3□	Probably 4 Unknown
Sor	w requ	Completed	Resoluto	De Yun-	ste.	in Take IE	M. 1	24a. Was an	24b Were	autopsy findings available
Re	sician: The law certificate has b irector, page 2 s	d mc	Conjugate of	47	7.00			autopsy perform 1 Yes 2	ed? death	o completion of cause of ? es 2 2 100
Vital	en: T tificat tor, pă	0	25. Was case referred to medical	al coney	015t7	R-E	26. Place of De	eath (Check only one		
fν	× 20 0	To B	examiner? 1 — Yes 2 — No	Hospital:	ent 2 ERV	Outpatient 3 DOA		Home 5 ☐ Resider		pecify)
n of	ng Ph fter th neral	ü	27. Manner of Death 1 Death 1 Natural 5 □ Pend	28a. Date of Inju (Month, Da	ry y Year) 28b		njury at Work?	28d. Describe how	v injury occurred	
sio	tendi leath. tor: A the fu	cati		igation	une At homo	farm, street, factory, offi	Yes 2 No	28f Location (Stre	eet and Number or	Aural Route Number,
Division	or At after of Direct in by	Certification:	4 Homicide deten	mined 200 Flate of Iti	c. (Specify)	iami, sileet, lactory, on	00	City or Town,	State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medica	ing Physician: To the best I Examiner: On the basis of	f examination	dge, death occurred at th and/or investigation, in n	e time, date and plac ny opinion, death occ	ce, and due to the car curred at the time, da	use(s) and manner te and place, and c	as stated. ue to the cause(s)
	thin 2 than 2 than mplet	Medicai	one) 29b. Signature and title of certific	and manner st	a.eu.	29c. Lig	ense number	29	d. Date signed (Mo	onth, Day, Year)
	F 3 F 8	N	<b>\</b>	Many	cur	). 6	19502	- 1	MALCH.	20. 2401
	(1)		30. Name and address of person	n who completed cause of o	death (Item 23	a) (Type, Print)	Mentuck PANDALIS	VENT H	Spira	20, 200 £ Conton
	4		CRIANDO /3	3. CONANA	v n	2	PANDAUS	TOWN, A	id De	1(3.3
1	St Regis	ate	31. Date filed (Month, Day, Yea	32. Registr	rar's Signature	DAGE!	2			-

		1 - State Amend Item 24a p. Registrar		ryland / Depa ,03/24/04dbi	artment of F Ptificate of	lealth and M Death	Mental Hygi Re 2. Date of Death		) 4 0920!
Physic /Med	ical	Dorothy	Dorat		4- 67- 7		Month MOTUS	Day Ye	1 5:15 AM
Exam	ner	4a. Facility Name (If not institution, give Northwest Hospit	al		Randal			4c. County of C	more
Funera Director		213-38-6758	ex 7. Age ☐ M 2XF	(In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/21/19		Birthptace (State or Foreign Country) Maryland
aryland show	2	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
ith the M or 28a-f	Directo	MD Carrol  10e. Street and Number	-T	Westmir	10f. Zip Code		10	g. Citizen ot Wha	
DattImore, Intaryiand AILID-0030  permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturer, or Items 23a or 28a-f show month injury or other traumatic event, the Medical Examinating Invalled Totaling Invalled.	Funeral Director	129 S. Center St	12. Was Decedent Ender Armed Forces?		21157 Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		American Indian, White, etc.
-UUSD hours aft sturel; or	þ	1 Never Married 2 Married 3 Widowed 4 XDivorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:	1	Specify: .	White ess/Industry
Maryland 21215-0035 nd 2 should be filed within 72 hours alt lith and Mental Hygiene. 27 is marked other then "nature!, or rtraumatic event, the Medical Exert	Completed	(Specify only highest gra  Etementary/Secondary (0-12)  12	College (1-4or 5+	(Give	kind of work done DO NOT use retired	during most of work	king	Hospit	
land 2	To Be C	17. Father's Name (First, Middle, Last) George Charles F					ne (First, Middle, M ne Murie	aiden Sumame)	
i, Maryla end 2 should eatith and Men n 27 is marke er traumatic	-	19a. Informant's Name/Relationship ( Deborah Cushing	**		ng Address (Street Tred Avo				te, Zip Code) 1220
Battimore, IM  Depart Peges 1 end 2  Department of Health in mportant: If item 27 i eny injury or other tra		20a. Method of Disposition  1	Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other plac	ce)	Date 2	0c. Location - City	y or Town, State
baltimory permit. Peges Department of the Important: If ite eny injury or of		21. Signature of Funeral Service Licer		10.0	2. Name and Addre	ss of Facility $ {f E}_{ullet} $		hn funer	all, Maryland al Home, P.A. 21087
Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only tmmediate Cause (Finat disease or condition	plications that an sed tone cause on each tine	he death. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
/Medica Examine		resulting in death)	Due to for as a	consequence of):	18				
icate be executed physicien and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
	/Medicai	IF FEMALE:	d23c. tf yes, outcome o	f prognancy					
, P.O. BOX 6 that the death certificated by the attending posteron detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	Day Year
ecords, P.O. law requires that the as been signed by th	þ	Part II. Other significant conditions of	contributing to death but	t not resulting in the u	inderlying cause giv	en in Part I.			te to the cause of death?  Probably 4 \ Unknown
T e e e	Completed						24a. Was an autopsy perform	ed? prior	e autopsy findings available to completion of cause of h? Yes 2 \sum No
Or VITAL Physician: The This certificate rall director, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Mnpatien	t 2 DER/Outpatie	nt 3□ DOA Oth	or	th Check only one		Specify)
ding h. After	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day	28b. Time o	f 28c. Injur		28d. Describe hov		
DIVISION Hospitel or Attentity hours after death Funerel Director: tely filled in by the		4 Homicide determined	building, etc.				City or Town,	State)	r Rural Route Number,
To the Hospital. within 24 hours a youthe Funeral Completely filled	edical	29a. Certifier  (Check only one)  1 Certifying Phase Cert	nysician: To the best of miner: On the basis of and manner state	examination and/or in	h occurred at the till vestigation, in my o	me, date and place, pinion, death occu	, and due to the car rred at the time, da	use(s) and manne te and place, and	or as stated. due to the cause(s)
To t To t	×	29b. Signature and title of certifier	Sind		29c. Licens	3 3 7 4		d. Date signed (M	fonth, Day, Year)
		30. Name and address of person who  31. Date filed (Month, Day, Year)	SICA	North	Print) Wes	Hosp	HAL		
S Regis	tate trar	MAR 2. 4 2004	32. Registral	rs Signature	E.	,			

			State of Maryland  1- For State RegistrarAMEND ITEM #19a PER INF G829 3/2					000	 )4 09206
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last)  JEAN DESMOND  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De	2. Date of Dea Month MARCH	th Day Ye	4 9:45 M
	Funeral		Mercy Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. In	.,	Balt 1  If Under 1 Year  Months Days	If Under 24 H	rs. 8. Date of Birth	Ball	IMONE Birthplace (State or Foreign Country)
E	Director		213-36-6096 1 M 2 F 65  Usual Residence of Decedent  10a. State 10b. County 10c. City	Yrs.			12-16-		Md
	death with the Maryland oms 23a or 28a-f show	Funeral Director	Md. NA Ba	ltimor	*e			0g. Citizen of What	TY∑Yes 2 □ No
	23a or	ralD	3013 Ailsa Ave.		21214			USA	
9000	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Marical Example in content traumatic event, If a Marical Example in content in a later withing at	by	11. Marital Status  1 Never Married 2  Married 3  Widowed 4  Divorced  12. Was Decedent Ever in U.S Armed Forces? 1 1 Yes 2 No If Yes, Give Year or Dates:	II	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 ☑ No	spanic Origin? n, Mexican, Pu Specify;	(Specify Yes or No- erto Rican, etc.)	Specific	merican Indian, White, etc. Black
21215-0036	d within 72 h jiene. ir then "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12th grade	(Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired ashier Ma	furing most of v		16b. Kind of Busine	ss/Industry
	ld be filed ental Hyg ked othe Ic event,	Be	17. Father's Name (First, Middle, Last)		abilizer ne	18. Mother's N	lame (First, Middle, I	Maiden Sumame)	
Maryland	2 should and Me Is mark sumation	ပ္	Charles Desmond  19a. Informant's Name/Relationship (Type, Print) //NIECE		g Address (Street a	Mam: und Number or	Le Rural Route Number	Franci City or Town, State	
	Pages 1 and nent of Health int: If Item 27 iry or other tr		Tanja Desmond Daughter  20a. Method of Disposition 1 Daughter  20b. Pl. Cell Cell Cell Cell Cell Cell Cell Cell	ace of Dispos	Ailsa Ave sition (Name of natory or other place		Date Mo	21214 20c. Location - City	or Town, State
Baltimore,	permit. Pag Department Important: I any injury o		1 1 Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	22.	edral Cen Name and Addres arch F.H.	s of Facility	Balti	Baltimore more, Md. North Ave	21202
8760,	Carath certificate be executed by sician and a strending physician and dor use as the burial-transit	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  Due to (or as a consequence of the conseque	ience of):		ngop			Approximate Interval Between Onset and Death Only (Unit) W7
.O. Box 68	death certif e attending d for use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal: 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
<b>Q</b>	The law requires that the tee has been signed by the sage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not result SC N I ZOPN NEWTA	iting in the un	iderlying cause give	on in Part I.			e to the cause of death?
al Reco	Ø 14	Completed					24a. Was ar autops perform 1 □ Yes	y prior t	
Division of Vital Records,	tending Physicath.  Tor: After this the funeral dis	Certification; To Be	27. Manner of Death  1	ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	4 🗆 Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	ince 6 □Other (S	
D	ē ģiģi⊊		4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)  29a. Certifier Certifying Physician: To the best of my know	)	•	e date and pla	City or Town	, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only one)  2 Medicaf Examiner: On the basis of examinati and manner stated.  29b. Signature and title of certifier	on and/or inv	estigation, in my op	inion, death oc	curred at the time, da	ate and place, and d	lue to the cause(s)
)	7		30. Name and address of person who completed cause of death (Item	MIN 23a) (Type I	29c. License		nt, mi	ANCH O	71, 200Y
	V		JUNGATBONACUM 30154 PAU	12 Pl	Bal	TIMI	nt, mi	121201	1
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Formation of Protein Protein Services and Services of Protein Services and Services of Protein Services and Services of Servic			1. Decedent's Name (First, Middle, Last) $\mathcal{N}oR$ $\mathcal{M}$ $\mathcal{A}$	)		DAVI	5	, Month ,	Day Year	12:01 D.
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23. Part. Enter the Sissass, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause Final Immediate Final Immediate Cause Final Immediate Cause Final Immediate Final Immediate Cause Final Immediate Final Imme	ges 1 If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State			10/0/			
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23a Part Enter the fishes as or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Barrieron Chesis and Depth (Processing) and a cause of Final death of complication resoluting or death)	Dep de de de de de de de de de de de de de		> youlder-	(USA	1					-
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Due to [or as a consequence of]:    Due to [or as a consequence of]:	/Medical		resulting in death)	Due to (or s a	consequence of):					ZWECKS
Due to (or as a consequence of):  d.    FFEMALE:   23c.   If yes, outcome of pregnancy	Examiner	_	Sequentially list conditions,	corv	nany	artery ,	desease			>Syecers
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25. Was case referred to medical examiner?  1	that the hold by detact	y Ph		ntributing to death but	not resulting in th	e underlying cause gi	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
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27. Manner of Death   Natural   2   Accident   1   Yes   2   No		Соп						perform	ed? death?	
27. Manner of Death   Natural   2   Accident   1   Yes   2   No	sicien	m	examiner?	fospital:		Ott	nor			
MCC 22000 ATTENDING DS6399 March 16, 2004  30. Name and address of on who completed cause of death (Item 23a) (Type, Print)  JNA + ARIAN NO 301 St. Pain St. Baltimir, NO 21201	두 두 등	-	27. Manner of Death			e of 28c. Injur	ry at			ecity)
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MCC 22 200 ATTENDING DS6399 March 16, 2004  30. Name (a) d address of on who completed cause of death (Item 23a) (Type, Print)  JNA & ARIAN NO 301 St. Paul St. Baltimir, NO 21201	s after de s after de al Directo	Sertiflo	determined	28e. Place of Injury building, etc.	y - At home, farm, (Specify)	street, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	tural Route Number,
MCC 22000 ATTENDING DS6399 March 16, 2004  30. Name and address of on who completed cause of death (Item 23a) (Type, Print)  JNA + ARIAN NO 301 St. Pain St. Baltimir, NO 21201	e Hospil 24 hour e Funere letely fill∉		(Check only 2   Medical Exami	ner: On the basis of e	xamination and/o	eath occurred at the ti r investigation, in my o	me, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
30. Name and address of son who completed cause of death (Item 23a) (Type, Print)  J NA + ARIAN NO 301 St. Part St. Baltiman, NO 21201	To th withir To th comp	Me	29b. Signature and title of certifier							
JNA EARLAN MD 301 St. Paul St. Baltimon, MD 21201	`		> MC6 3< 26	U) A	MOUSTI	G DS6	3399	1	lairch 1	6,2004
	1		EASA A A A A A A A A A A A A A A A A A A	ompleted cause of dea	ath (Item 23a) (Ty	pe, Print)	Chrisie	MO	2120	(
	Sta	te	1 1 2 1 1 1	-		21. 000		1 1-30		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 50 **Physician** Michael J Dougherty 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Franklinda 8. Date of Birth Month, Day, Yei May 17 1924 1 Year Days If Under 1 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1∏M 2□F Months Hours Baltimore City, Md 79 217 20 8202 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c, City, Town or Location 10a. State 10b. County "natural", or itams 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Baltimore County Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 208 Henry Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW Ⅱ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2€ No Specify: Specify: White  $W \coprod$ <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, important: If item 27 is marked other then any jointy or other traumatic event, ILEM 2008. Russell Baker Co. Real Estate Agent 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael J Dougherty Bertha L Moberly ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Henry Avenue Baltimore, Maryland 21236 Nancy L. Dougherty 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gdns. March 24 2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Squature of Funeral Service Licenses Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 MALL MICH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) xem **Physician** /Medical Dua to (pr as a consequence of) Examiner neumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Completed by Physician/Medical Examiner burial-transit that initiated events resulting in death) Last The law requires that the death certificate/69/6xecu Due to (or as a consequence of): Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Dav Year detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, **p**9 1 Yes 3 Probably 4 Unknown should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 1 ☐ Yes 2 ☐ No 2 17 No 1 ☐ Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Mannef of Death Medical Certification: Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 0058671  $2\infty$ 

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DHMH 17 Rev 1/2001

State 31. Date filed (Month, Day, Year)
Registrar MAR 2 4

30. Name and address of person

Jon

(Month, Day, Year) 32. Registrar's S

- 9000 Franklin Square Drive Bultimore 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)-

**Funeral** 

Director

with the Maryland

2 should be finance and Mental F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 18 per \$1 G82903/29/0/dhb Department of Health and Mental Hygiene [] [] [] 09209 1- State AMEND ITEM #2 PER PHY G829 3/24/04 JCertificate of Death Rag. No. 2. Date of DeathMAR 18 2004 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2018 March <u>Edwards</u> Vivian Tobias /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hos Pital Sinai Baltimore If Under 1 Year If Under 24 Hrs. ot 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number Days Months Hours 1 ☐ M 2 🗓 F 1 - 3 - 1920214-24-0650 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Yes 2 No N/A Balto Md Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 2 Coral Berry Court USA Funera Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 27 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Westinghouse College (1-4or 5+) Electronic Technician 12th grade 5 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Boyd Henry Tobias Minnie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Edwards - Husband 2 Coral Berry Ct Balto, Md 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3-23-2004 Balto, Md Woodlawn Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, br heart failure. List only one cause on each line. 4300 Wabash Avenue Balto, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 8 months pancreatic cancel Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 **Z**No 25. Was case referred to medical examiner?
1 X Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 XEP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide

item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at os 1 and 2 s of Health an item 27 is Baltimore, Pages nent of I permit. Page Department of Importent: If eny injury or once. Physician /Medical **Examiner** Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760 Physician/Medical Division of Vital Records, þ To the Hospital or Attending Physicien: Be Certification: To this death. after death filled in by 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely within 2 To the 29b. Signature and little of certifier D0058947 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) .0

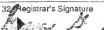
29c. License number

29d. Date signed (Month, Day, Year)

2401 W Belvedere Baltimore MD 21215 Vander Velde 31. Date filed (Month, Day, Year)

State Registrar

MAR 2 4 2004



			1 = For State Registrar	State of Maryland /	Department Certificate		Mental Hygie	- ZHIIIc	09210
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	7	dee		2. Date of Death		3. Time of Death 7.20p. M
	Examin		4a. Facility Name (If not institution, give	rare	Ba	own, or Location of De		4of County of Death	
	Funeral Director	•	5. Social Security Number 6. Security Number 6. Security Number 11 11 11 11 11 11 11 11 11 11 11 11 11	7. Age (In yrs. last)	yrs. If Under 1 Months	Year If Under 24 H Days Hours Mi		22 Wes	place (State or Foreign Intry) Tudies
	Maryiand -f show list at	tor	10a. State 10b. County	10c. City, To	own or Location	)			10d. Inside City Limits 1
:	n with the	ai Director	10e. Street and Number	ACONICO >	10f. Zip (	Code 121 M	10g.	Citizen of What Cou	intry?
36	nours after death with the Maryland turel', or Heme 23a or 28a-f show al Examiner must be notified at	by Funerai	11. Marital Status  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	13. Was Decede If Yes, speci	ent of Hispanic Origin? fy Cuban, Mexican, Put No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White	
וֹטָ ו	within 72 hours ene. than "natural", he Medical Exa	Completed b	15. Decedent's Ed (Specify only highest gra	ucation 16	6a. Decedent's Usual (Give kind of work life. DO NOT use	k done during most of w	rorking 16t	b. Kind of Business/Ir	
21	Hygi other	Be	17. Father's Name (First, Middle, Last)		House	18. Nother's N	ame (First, Middle, Mai	Privatiden Surname)	re ·
-	12 should be h and Mental 7 ie marked o traumatic ev	T <sub>o</sub>	19a. Informant's Name/Relationship (1	(A 1.	9b. Mailing Address	(Street and Number or	Rural Route Number, C.	ity or Town, State, Zi	ip Code)
	0 0 = =		20a. Method of Disposition  ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State ceme	of Disposition (Name of the property) of other of the property	e of her place)	3/29/04	c. Location - City or T	own, State
	permit. Page Department o important: If eny injury or once.		* 4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	7	ver Name and	Address on Facility	eene Fu	weral S	Services 1212
	Physician		23a. Part1. Enter the disease, or composition, or heart failure. List only Immediate Cause (Final disease or condition	bilications that caused the death. Done cause on each line.			iac or respiratory arrest,	20515	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence					I (CAVES
	be executed icien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.					· · · · · · · · · · · · · · · · · · ·
	y s	cal	resulting at osatti) Last	Due to (or as a consequence d.	ce or):				
O. Box 68	The law requires that the death certificate be exite has been signed by the attending physicien tage 2 should be detached for use as the buria	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy  1 Live birth 2 ☐ Fetal de:  4 ☐ Pregnant at time of death  9 ☐ Unknown	ath 3 □Ectopic pre			23d. Date of deliv Month	very Day Year
rds, P.O.	quires that t en signed by uld be deta	ed by Ph	Part II. Other significant conditions of	ontributing to death but not resultin	g in the underlying ca	use given in Part I.		cco use contribute to	1.
I Records,	The la	Complete					24a. Was an autopsy performed	d? prior to co	copsy findings available ompletion of cause of
of Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other & a	eath (Check only one)		
Jo I	g Phy er this neral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/ 28a. Date of Injury (Month, Day Year) 28		Bc. Injury af Work?	Home 5 Residence		ify)
Division	or Attending ter death. irector: After n by the funer	Certification:	1 Xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	1	М	1 Yes 2 No	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my knowler niner: On the basis of examination and manner stated.	and/or investigation,	in my opinion, death of	curred at the time, date	and place, and due	to the cause(s)
	To the within To the Comple	Med	29b. Signature and title of certifier	hels.	290	D-12640	29d.	Date signed (Month)	Day, Year)
	m		30. Name and address of person who	completed cause of death (Item 23	Ba) (Type, Print)	R Dr.	Towson	MDZ	1204
1000	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature		1			
DHI	MH 17 Rev 1/2		MAR 2	4 2004 Bener	10	porker	<u> </u>		

			State of Ma			ealth and Me			
		1 - State Registrar	0.0.0		rtificate of D		, ,	No. 2001	11000
Physi	ician	1. Decedent's Name (First, Middle, L	.ast)			2.	Date of Death	Day Year	3. Time of Death
	dical	John Thomas Forne 4a. Facility Name (If not institution, g			4b. City, Town, or l		March	21, 200 4c. County of Dea	
		626 Sunset Strip			Brooklyr	n Park		Anne Ar	
Funera Directo		5. Social Security Number 6. 215–24–0555	Sex 7. Age 1	(In yrs. last birthday)  5 Yrs.	If Under 1 Year Months Days		Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)
D		Usual Residence of Decedent					ugust 2	1,1940	laryland
Manyla f ahov	ō	Maryland Anne	Arundel	Brooklyn					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
death with the Maryland ms 23s or 28a-f show rmust be notified at	Director	10e. Street and Number	Arunder	DIOOKIYII	10f. Zip Code		10g.	Citizen of What Co	
ath with	raiD	626 Sunset Strip			2	21225		Unite	ed States
ler dez Items	Funeral	11. Marital Status 1 ☐ Never Married 2 [X] Married	12. Was Decedent E Armed Forces?		Was Decedent of His If Yes, specify Cuban	spanic Origin? (Specify n, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	erican Indian, te, etc.
0036 hours after turel, or the	Ď	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes 2√∑ No	Specify:		Specify: Wh	ite
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylan th and Mental hygiene. T is marked other than "natural", or items 23s or 28s-f show treumatic event, it a Medical Exaction or matter the inclined at	Completed	15. Decedent's (Specify only highest g		(Give	dent's Usual Occupat kind of work done du	uring most of working	16b	. Kind of Business	/Industry
d 21215- filled within 72 Hygiene. other than "nai	фшо	Elementary/Secondary (0-12)	Callege (1-4or 54	+)	DO NOT use retired) Carpenter			Bu	ilding
be filed at the filed of the filed other dother went, the	BeC	17. Father's Name (First, Middle, Las	st)			18. Mother's Name (F		den Sumame)	
arylan should be ind Mental i marked o	2	Charles Akins						Unknown	
Mar and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship Brenda Forney /		1.0		nd Number or Rural R Venue, Balt			
0, 2, 2, 5, 5, 5		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place)	Date		Location - City or	
Baltimore, permit. Pages 1 av Department of Hea Importent: If Nem		1  Burial 2  Cremation 3  1  Other (Special Control of the Contro		Cedar Hil	ll Cemeter	y 3/26/0			rk, Maryland
Baltimor permit. Pages Department of timportent: If its any injury or of	eg G	21. Signature of Funeral Service Lic	ensee.	22	2. Name and Address	of Facility Hubba	rd Fune	ral Home,	Inc.
A D IN FORM		23a. Part 1. Enter the diseas or co	mp ca ions that caused the caused the cause on each line	the death. Do not ent	er the mode of dying,	.ns Avenue, , such as cardiac or re	Baltimo espiratory arrest,	ore, Mary	land 21229 Approximate
Physicia	n	shock, or heart failure. List only Immediate Cause (Final disease or condition	THE STATE OF THE S	mall (fl)					Interval Between Onset and Death
/Medica Examine		resulting in death)	Due to (or as a	consequence of):	100)	WICV	-		3 7.00 1.70
		Sequentially list conditions, if any, reaumy to immediate	b. Due to (ur as a	. ວັນກ່າວອະຖຸນອກີເວີຍ ປ່າງ.					
cuted	Examiner	fl any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
3760, ate be executed sysicien and he burial-transit	I Ex	resulting in death) Last	Due to (or as a	consequence of):					
687 ificate t g physical as the t	edicai		d.						
BOX 68 leath certificate attending phy. for use as the	M/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy			23d. Date of del	ivery
LO. BOX 68  If the death certifica by the attending ph tached for use as if	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t		Other (specify)			Month	Day Year
that the ed by detacl	/ Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the ur	nderlying cause given	n in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
COLDS, P w requires that been signed to should be detailed	ed by						1 / Yes	2 No 3 Pr	obably 4 Unknown
Hecords, P The law requires that the has been signed b	Completed						24a. Was an autopsy	24b. Were au	itopsy findings available completion of cause of
							performed 1 Yes 2	? death?	2□ No
	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ☐ ER/Outpatien	Othor	26. Place of Death (C. 4 ☐ Nursing Home		6 COther (0	-Z.)
O OT ng Phys ter this neral di	T :U	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day				. Describe how in		city)
DIVISION ( If or Attending F after death. Director: After In by the funeral	catic	2 Accident investigati 3 Suicide 6 Could not	on		M 1 ☐ Ye	es 2 □No			
DIVI afor A after after Direct	Certification:	4 Homicide determine	building, etc.	ry - At home, farm, str (Specify)	eet, factory, office	281.	City or Town, St	t and Number or Ru tate)	iral Houte Number,
DIVISION  To the Haspitel or Attending within 24 hours after death.  To the Funerel Director: Attencompletely filled in by the fune.	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	Physician: To the best of aminer: On the basis of	examination and/or inv	n occurred at the time vestigation, in my opin	a, date and place, and nion, death occurred a	due to the cause	e(s) and manner as and place, and due	stated. to the cause(s)
ro the vithin 2 ro tha comple	Med	29b. Signature and title of certifier	and manner state	ed.	29c. License r	number	29d. I	Date signed (Monti	h, Dey, Year)
	100	I Che mis	ul	_	122	782	Ma	nch 24, 24	004
9		30. Name and address of person who				and Nalti			
5	State	31. Date filed (Month, Day, Year)	32. Registrar	r's Signature		eet Balton	we hay	land of	423
Regis	strar	MAR 2 4 2004	Genera	19 As	rocks				

				epartment of Health and Mental H	Hygiene 2004 09212				
	Physici /Medio Examin	al	Wilbert L. Faulkes, Jr	2. Date of Month  4b. City, Town, or Location of Death	Day Year				
	Funeral Director		5. Social Security Number  5. Social Security Number  6. Sex  7. Age (In yrs. last birth)  313-58-6815  Usual Residence of Decedent	day) If Under 1 Year   If Under 24 Hrs. 8. Date of Months   Days   Hours   Min.   Oct	Birth Day, Year)  9. Birthplace (State or Foreign Country)				
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "netural", or Items 23e or 28e-f show other traumatic svent, Ite Medical Evantiest must be rediffed at	ector	10a. State 10b. County 10c. City, Town	Baltimore 101. Zip Code	10d. Inside City Limits 1				
		by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1   Yes 2 No   If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2200 Specify:	No- 14. Race - American Indian, Black, White, etc.  Specify: Diam's				
		To Be Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry Poultry				
Maryland			17. Father's Name (First, Middle, Last)  Wilbert L. Fowlkes Sr.	18. Mother's Name (First, Mide Mailing Address (Street and Number or Rural Route Num	Burch				
Baltimore, 1	permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr once.		1 Bunal 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	Disposition (Name of crematory or other place)  Zion  3-35-01	20c. Location - City or Town, State  Baltimore, MD				
Bal	permi Depa Impo any ir		23a. Part Eprer the disease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line.	22. Name and Address of Facility  Cary P. Maych F/H 2-  It enter the mode of dying, such as cardiac or respiratory	70 Freshillon RSS Bally MD y arrest, Approximate Interval Between Onset and Death				
.O. Box 68760,	or Attending Physicien: The law requires that the death certificate be executed there death.  Iter death.  In position and inspector. After this certificate has been signed by the attending physician and in position in by the funeral director, page 2 should be detached for use as the burial-transit in position.	Physician/Medical Examiner		); );	8 minuhs 5 y ears				
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year				
Records, P.		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
Vital Rec		Be Completed	25. Was case referred to medical examiner?	24a. W au pe 1 □ Yes 26. Place of Death (Check onl	topsy rformed?  2 1 No  topsy rformed?  2 1 Yes 2 No				
Division of V		Certification: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	ne of ury At Work? M 1 Yes 2 No 28f. Location	sidence 6 Other (Specify) le how injury occurred  (Street and Number or Rural Route Number, Fown, State)				
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.						
)	To T with	Σ		29c. License number D-60203  ype, Print) Street Johns Hopkins Bo	29d. Date signed (Month, Day, Year)  Morch 22, 2004				
	Sta Registr		Rosalyn Juergens 1650 Orleans  31. Date filed (Month, Day, Year)  MAR 2 4 2004  MAR 2 4 2004	Street Johns Hopkins Bo	ettimore Maryland 21287				

State of Maryland / Department of Health and Mental Hygiene 2 09213 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year BERNICE FRAZIER 3:200M larch 15 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENERAL MARYLAND DAHIMDRE HOSPITA B Date of Birth (Month, Day, Year) 3/21/20 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M X□F 214 18 0490 83 Director MD. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show The Medical Examiner must be notified at 1 Yes 2 □ No Director MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 1812 N. DUKELAND ST. 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify. Specify: BLACK þ 3 ♥ Widowed 4 Divorced 'natural' Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICE HUTZLER CO. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health and Mental H tent: If item 27 is marked ot Be ALBERT CARR ROSIE P. CARR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA CARR 58 S. MONASTERY AVE. BALTO. MD. 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department o Importent: If sny injury or once. ARBUTUS PARK 3/22/04 ARBUTUS, MD. 21. Signature of Furreral Service Licensee FUNERAL PL. BALTO. 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Devere Physician /Medical Due to (or as a consequence of): **Examiner** Severe HEAR+ Failure ongestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit Devere Renal and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physicien should be detached for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 1 Yes 2 No 1□ Yes 2 No or Attending Physician: Be completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 V npatient Certification: To 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 89474 Dr Hosseim M.D. March 15,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Hosseini, Shahrzad GENERAL HOSPITAL 32 Registrar's Signature MARYLAND 31. Date filed (Month, Day, Year) State MAR 2 4 2004 Registrar

			. For	State of Mary			of Health ar	•	giene	egible.	
			1 - State Registrar		Ce	rtificate	of Death		Reg. No.	2004	09214
ī	Physici	an .	Decedent's Name (First, Middle, Last					2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Brenda Good		er	T		March			6:40P <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, give				wn, or Location of	Death		ounty of Death	
	Funeral		Rockville Nursin  5. Social Security Number 6. Se	<u> </u>	yrs. last birthday,	It Under 1				ntgomer 9. Birth	
	Director		410-30-0338	]M 2X)F	33 Yrs.	Months [	Days Hours	Min. (Month, Da	25, 19	(ear) 9. Birthplece (State or Foreign Country) Kentucky	
	pu *		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or L	ocation					10d. Inside City Limits
	Aaryle I sho	ō									1XXYes 2 □ No
	286-	Director	Maryland Montgome  10e. Street and Number	ery	Rockvill	10f. Zip C	ode		10g. Citize	en of What Co	untry?
	h with	I D	303 Adclare Road			208	850		Unite	ed Stat	es
	ems 2	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Deceder	nt of Hispanic Origin Cuban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)		1. Race - Amer Black, White	ican Indian,
36	or It	y Fu	1 Never Married 2 Married	1107]Yes 2 ☐ No T <sub>e</sub> If Yes, Give	Vorld	1 ☐ Yes 25		,		Specify:	, 010.
21215-0036	within 72 hours after death with the Marylend ene. than "natural", or Items 23a or 28e-1 show ins Medical Exemiter mail be notified at	ed b	3   Widowed 4 □ Divorced  15. Decedent's Edu		Var II	dent's Usual (	Occupation		16h King	Wh	ite
5	n n	piet	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work DO NOT use	done during most o	of working			County
2	giene giene er tha	To Be Completed by Funeral	Clementary/Secondary (U-12)	5+	Lib	rarian				Libra	-
Maryland	be file tal Hy d oth		17. Father's Name (First, Middle, Last)				18. Mother	s Name (First, Middle	, Maid <b>e</b> n S	umame)	
<u>\</u>	Men Marke Marke		William Raymond		(			a Head			
Mai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Modical Examinar ratal te notified at ance.		19a, Informant's Name/Relationship (T)					or Rural Route Numb			
ē,	Heali Heali tem 2		Alan R. Fischler/ 20a Method of Disposition	2	Ob. Place of Disp	osition (Name	of	d, Lyndhun		Ohio 4 ation - City or 1	
Baltimore,	Pages ent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ I  3 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Parklawn Parklawn Pa	matory or othe Memor	iaI Ma	rch 23,	Pooks	71110	Maryland
alti	mit. I pertm yorter inju		21. Signaturi Funeral Service Licen						Pump	rey Fu	neral Home/
m	Depermine Depe		1.3どのしく	eu. MC	00803 R	ockvill	le, Inc. Le, Maryl	and 2085	10ntgc )-2805	omery A	neral Home/ venue
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the ne cause on each line.	death. Do not en	ter the mode of	of dying, such as ca	ardiac or respiratory a	irrest,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition a Myocardial Infarction						100	Onset and Death One Hour	
			Due to (or as a consequence ot):								
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Ó	te be executed ysicien and e burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):								
8760,		lical		d							
x 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE:	23c. It yes, outcome of pr	agnanau	3					100.00
Вох	atten for us	cian	in the past 12-months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	□Ectopic preg □ Other (spec			23	Id. Date of deli- Month	very Day Year
P.O.	the d	hysi	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unknown			"//				
	s thai	y P							lobacco use	co use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown	
ğ	w require been sig should t	ted	Parkinson's Disease						Yes 2∑		
Vital Records,	e law r has be je 2 sh	Completed						24a. Was	psv	24b. Were aut	opsy findings available ompletion of cause of
Œ	: The cate h	Con						perfo 1 ☐ Yes	ormed? 2∭ No	death?	2 No
Vit.	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:			Othas	f Death (Check only			0.00
o	Physical distribution	1.	1 ☐ Yes 2X No  27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time o		11 3 DOA 4 Mursing			Home 5 ☐ Residence 6 ☐ Other (S)  28d. Describe how injury occurred		ify)
on	Attending In death.	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury   28b. Time of   28c. Injury at   Work?							
Division of	or Attene after death Director:	tiflea	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street						t and Number or Rural Route Number,		
ō	italor irs after is Dia led in	Certification:	building, etc. (Specify)  City or Town, State)								
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Exem	sician: To the best of my ner: On the basis of exa	knowledge, dea mination and/or in	th occurred at ivestigation, in	the time, date and my opinion, death	place, and due to the occurred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	ithin 2 o the	Med	one) and manner stated.  29c. License number 29d.						d. Date signed (Month, Day, Year)		
)	F 3 F 8		ibalata Ind Mo								
	12/1		30. Name and address of person who c		(Item 23a) (Type		31839		march	19, 20	JU4
	\"		Christopher Dunf	ord, M.D. 6	15 West	Montgo	mery Blvo	l., Rockyi	11e.	<u>Marvlar</u>	nd 20850
	Sta		31. Date tiled (Month, Day, Year)		Signature		-			<del></del>	
	Registi	ell	MAR 2 4 2004	But side and the	The state of the s	a Tu					

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARCH 2004 6:59 PM DAVID ANDREW FOGGO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Year Til Under 24 Hirs 8. Date of Birth (Month, Day, Ye Jul 23, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours 146-18-7746 80 1923 New Jersey Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: if item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Modical Examinar rough be notified at Frederick 1 Yes 2X No Maryland Director Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7048 Catalpa Road. 21703 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status TYDYes 2 No 1943-If Yes, Give Year or Dates: 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Distribution I.B.M. Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Adamson Foggo Gladvs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Paula Gannon Foggo/Wife 7048 Catalpa Road, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l Cemetery Mar 25, 2004 Ft. Myer, Virginia 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Reeney & Basford P.A. Funeral Home

106 Fast Church St, Frederick, Maryland 21701

23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Internal Course (Fig.) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia manth /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68766 the attending physicien Physician/Medical signed by the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospitel or Attention within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) Shah 051643 Hiron, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rederick Thomas Thonson Di mD C 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 4 2004

RPD			1 = For Unpend Item#23a,2	State of Maryla 7,Per MEG830,4/	nd / Departm <b>/7/0<del>4e</del>e</b> ertific	ent of Health and cate of Death	Mental Hygi	ene () () (	09216
	Physici /Medi		1. Decedent's Name (First, Middle, Last,	RRON L.	Goss	>	2. Date of Death Month March 2	1, 2004 Year	3. Time of Death 0246 A
317	Examir Funeral Director		4a. Fecility Name (If not institution, give 501 East Preston S 5. Social Security Number 6. Security Number 10	Street Apt 20	4 Bá	City, Town, or Location of De altimore Inder 1 Year   If Under 24 H ths   Days   Hours   Mi	rs. 8. Date of Birth	4c. County of Dea	hplace (State or Foreign
	ō	tor	Usual Residence of Decedent  10a. State  10b. County	10c. C	ity. Town or Location	ME	100	7730 1147	10d. Inside Oity Limits 1 Dres 2 □ No
	ath with the	Funeral Director	501 E. PREST	ON St. Ap	7205	. Zip Code 2120	2	g. Citizen of What Co	A.
5-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show item Maryleal Exaction transless notified at	by	11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in N Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 □ Y€	ecedent of Hispanic Origin? specify Cuban, Mexican, Pue es 2 Mo Specify:		14. Race - Ame Black, Whit Specify:	e, etc. ACK
2121	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene if Health and Mental Hygiene "natural", or Items 23e or 28e-f show tiem 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, if e Medical Exaction or install to notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's (Give kind o life. DO NO	f work done during most of w Truse retired) VVRSE	rorking	6b. Kind of Business/	
Maryland	should be fill nd Mental H marked ott	To Be	17. Father's Name (First, Middle, Last)  HARLES  19a_Informant's Name/Relationship (Ty	055	19b Mailing Add	ress (Street and Number or I	ame (First, Middle, M	KUSH	Tin Codel
	es 1 and 2 shoof Health and of Health and 1 frem 27 is m. r. other traum		DANETA F. BE 20a. Met/fod of Disposition 1 Met/aurial 2 Cremation 3 CR	THEA SISTE	R 5724 Place of Disposition pemetery, crematory	WIWWTOI (Name of	V AVE. !	Oc. Location - City or	D 21239
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr ance.		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		ING MEMI 22. Nam Lanz	RIAL PARK 3 e and Address of Facility V	WOHN C.		MARYLAND NECAL HOME RYLAND 2 121-
	To the Hospital or Attending Physician: The law requires that the death certificate be executed by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and in process prompietely filled in by the funeral director, page 2 should be detached for use as the burial-transit as in process.	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	Cations that caused the deale cause on each line.  Acute and Chir  Due to (or as a consection)  Due to (or as a consection)  Due to (or as a consection)	quence of):		ac or respiratory arres		Approximate Interval Between Onset and Death
O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ♣Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 ☐Ectop	ic pregnancy (specify)		23d. Date of deli Month	very Day Year
Ω_		۾	Part II. Dther significent conditions cor	tributing to death but not re	sulting in the underlying	ng cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
al Records,		Completed					24a. Was an autopsy performe	ed?   death?	topsy findings available completion of cause of
Division of Vital		Certification: To Be	25. Was case referred to medical examiner?  1 \overline{\text{Yes}} \ 2 \subseteq No  27. Manner of Death  1 \overline{\text{M}} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	28a. Date of Injury (Month, Day Year)	Year) 28b. Time of Injury at Work?  M 28c. Injury at Work?  1 Yes 2 No  28f. Location (Street and Number or Ru				
Ω		Medical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	ician: To the best of my knier: On the basis of examinating and manner stated.	owledge, death occur ation and/or investiga	red at the time, date and plac tion, in my opinion, death occ	ce, and due to the cau	ise(s) and manner as e and place, and due	stated. to the cause(s)
		Me	29b. Signature and title of certifier  Dawhad  30. Name and address of person who co	helphe A	LD	29c. License number O.C.M.E.		d. Date signed (Month	
	(C)	ate_	Tasha Z Gree 31. Date filed (Month, Day, Year)	nberg M.D 32. Registrar's Sign	111	Penn Street,	Baltimore	, Maryland	21201
	Registr		MAR	2 4 2004	merca.	A hoar			

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 09217 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 Year **Physician** GASTON TROGDON 19 RUBY MARIE ll:a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore 5446 Cedonia Ave. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-31-44 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2 👽 F Yrs. Director 59 216-42-3987 Md. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location ir than "natural", or items 23a or 28a-f ehow the Medical Examinat must be notified at 10a. State 10b. County 10d. Inside City Limits Y☐ Yes 2 No Director Baltimore Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21206 5446 Cedonia Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: ۵ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Schools Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 is marked other thu any injury or other treumatic event, ITE 9068. Baltimore County Publiq 9TH GRADE Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hallaway Alberta Tiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Trogdon Husbanf 5446 Cedonia Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 3-22-04 Baltimore, Md Greenmount Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. March F.H. East 1101 E.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Ave. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** minstes disease or condition resulting in death) ( oranary /Medical Due to (or as a consequence ): Examiner DICLBET Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events yeas Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 🗀 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and life of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00052928 2004 Wes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 792 BALTIMGEE MARY ANNE NIDIRY MERRITT 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 4

		•	1 - For State Registrar	State of Maryland /	Department of Hea Certificate of De	Ith and Mental	Hygiene 200	09218
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Edythe  4a. Facility Name (If not institution, give s	.660	4b. City, Town, or Loca	Mont	1 1 000	04 9:50 PM
	Funeral Director		45 10 0117	7. Age (In yrs. last b.		Inder 24 Hrs. 8. Date	of Birth th, Day, Year) 9. E	N/A Birthplace (State or Foreign Country) MD
	e Maryland Be-f ahow	Director	Usual Residence of Decedent  10a. State 10b. County  Anne Av					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the 23a or 2		0 - 1	HILL AVENUE		060	10g. Citizen of What	SA
036	within 72 hours after death with the Maryland ene. Than "natural", or itema 23a or 28e-f ahow Te Medical Examinar mual Le notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispan II Yes, specify Cuban, Mi 1 ☐ Yes 2 ☑ No Sp	ic Origin? (Specify Yes exican, Puerto Rican, etc	or No- c.) 14. Race - A Black, W Specify: [	merican Indian, thite, etc.
9500-61212	be filed within 72 hours after death with the Marylar dat Hygiene.  I at Hygiene.  I the Wedical Examinar meal to redified at avant, the Medical Examinar meal to redified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation 16a completed)  College (1-4or 5+)  2 175	a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) HOMEMAK	_	16b. Kind of Busine	ss/Industry ESTIC
Maryland		To Be C	17. Father's Name (First, Middle, Last)  ISAAH RUS	SELL		Mother's Name (First, M ESTELLE	Hiddle, Maiden Surname)	
	d 2 should be and the and the and traum		19a. Informant's Name/Relationship (Ty) EDYTHE RIDDICA	K/DAUGHTER -	The second section is a second section of the second section in the second section is a second section of the second section in the second section is a second section of the second section in the second section is a second section of the second section in the second section is a second section of the second section in the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section of the second section is a second section of the second section of the second section of the second section of the second section of the second section of the second section of the second section of the section of th	VENUE BA	LTIMORE N	1D 21229
Baltimore,	Page nent o ent: If ury or		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	Mea	of Disposition (Name of ery, crematory or other place) ADW 11 dge	03 25 0	20c. Location - City 4 Elkridge	e MD
Bail	Departition Depart		21. Signature of Funeral Service License	99 H	22. Name and Address of VAMGHN C. G. S. S. BALTIMOR	PEENE FUNEI ENATIONALP	PAL SERVICES	EMD 21229
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do no cause on each line.  Preumonio  Due to (or as a consequence	b	ch as cardiac or respirat	ory arrest,	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence		_		
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ords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con  Congestive H	eart Failur	in the underlying cause given in		Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐	to the cause of death?  Probably 4 XUnknown
Vital Record	The ate h page	e Completed	25. Was case referred to medical			1281	autopsy prior t death / res 2 \( \begin{array}{ll} No \end{array} & \text{prior t death} \\ \text{1 \lefts} \text{Y} \end{array}	
ion of Vil	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	To B	examiner?  1 Yes 2 No H  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 ER/O 28a. Date of Injury (Month, Day Year) 28b.	Othor	28d. Desc	Residence 6 Other (S)	oecify)
Division	ital or Atte ins after de ral Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At home, I building, etc. (Specify)	larm, street, factory, office		ion (Street and Number or or Town, State)	Rural Route Number,
	To the Hospital or At within 24 hours after of to the Funeral Directompletely filled in by	Medical	(Check only 2 Medical Examir one)	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	and/or investigation, in my opinior	n, death occurred at the	time, date and place, and d	ue to the cause(s)
	L SO THE T		29b. Signature and title of certifier	lynn, PCY-	1 RES		March 18	
		*0	30. Name and address of person who co  Sochin Kalyar  31. Date liled (Month, Day, Year)	ombleted cause of death (Item 23a)  1. M. D. 300  32. Registrar's Signature	1 S. Hansver	Street B	March 18 altimore, M	10. 21225
	Sta Registi		MAR 9 4 28	(1)	And to			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** CHARLES VERNON GRANT March 18 2004 8:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CO BALTIMORE MANOR CARE-DULANEY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 12XM 2□F **Director** 215-22-9870 76 JAN 23 1928 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 3912 BAREVA ROAD Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene 12th grade FIRE FIGHTER BALTIMORE CITY F.D. permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg
Importent: If Item 27 is marked other
any injury or other traum---once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FREDDIE GRANT JEAN TARTER 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mable Grant/Wife 3912 Bareva Rd., Baltimore, Maryland 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 03-25-04 OWINGS MILLS, MARYLAND 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 05 **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. Completed by Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Ö 9□ Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ② No 24a. Was an 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1\_Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 30 Name death (Item 23a) (Ty 303 Bal avonBlud 0 31. Date filed (Mon egistrar's Signature 32. State Registrar

		•	For State Registrar	State of M	aryland .	/ Depa	artment rtificate	of H	ealth a Death	and M	ental Hy	giene Reg. No	2004	092	220
	Physici	an	Decedent's Name (First, Middle, Last,								2. Date of Dea Month	ath Day	/ Year	3. Time o	f Death
а	/Medic	al	Betty Marie Gorsu  4a. Fecility Name (If not institution, give				4b Ciby	Four or	Location o		March	20	2004 County of Dea		A
П	Examin		Johns Hopkins Bayv			ter		ltim		n Dealii		40.	N/A		
	Funeral		5. Social Security Number 6. Se	x / 7. Ag	e (In yrs. last	birthday)	If Under Months		If Under a	24 Hrs. Min.	8. Date of Birt	h Vest	9 Bir	tholece (State	or Foreign
п	Director		211-16-3332	]M 2☑F	7.	4 Yrs.	Months	Days	Hours	IVOH1.	Oct 4,	192	9 PĂ	ountry)	
	and w	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation	-						10d. Inside C	City Limits
	Mary -f sho	ğ	MD Baltimon	re	Balt	imor	e							1 🗆 Yes	2 12 No
	th the	lrec	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What C	ountry?	
	ath wi	rai	7919 Eastdale Roa				212		,				ted Sta		
21212-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be multiled at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	,	į	Was Deced II Yes, spec 1 ☐ Yes 2	/	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whi Specify: Whi	te, etc.	
<del>ر</del> ا	72 ho	eted	15. Decedent's Edu (Specify only highest grad		1	6a. Deced	dent's Usua kind of wor	i Occupa	ition uning most	of working	na	16b. K	nd of Business		
2	han han	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	kind of wor DO NOT us	e retired)				Own	Home		
2	filed v Hygie sther t	ပိ	17. Father's Name (First, Middle, Last)			Homer			18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
Maryland	S la b 🜷	To Be	Howard Hartman						Edna		known				
ary	s 1 and 2 should In Health and Menistern 27 is marked other traumatic		19a. Informant's Name/Relationship (T)	rpe, Print)			-						r Town, State,	Zip Code)	
	1 and 2 Health tem 27 i		Robert Thomas Gor	such/Husb							ltimore				
Baltimore,	ges 1 it of H if ites or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State			natory or of			M	ar 24		cation - City or		
	it. Pa intmen intant: njury		* 4 Donation 5 Other (Specify)				ke Cr				004		tsville	, MD	
g	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licens	m			8717	Gree	n Pas	sture	ral Alt	e B	atives altimor		
*	Physician /Medical		23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Arteric	ine.	otic (						rest,		Approxima Interval Be Onset and	tween
	Examiner		Sequentially list conditions,	b	III-o-averates										
	nsit	nlne	Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ice oty.									
,	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequen	ice of):									
8760	ite be iysicia ne bur	cal		d											
9	certificate be executed Iding physician and Ise as the burial-transit	Med	IF FEMALE:										-	2.5	
P.O. Box	death e atter	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetel de	ath 3	Ectopic pro Other (spe						23d. Date of de Month		Year
	res that igned to be deta	by P	Part II. Other significant conditions co	ntributing to death b	out not resultin	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	se contribute to	the cause of	death?
ord	w require been sig should t		Arthritis		<del></del>		-				1 🗆 Y	es 21	□No 3□P	robably 4 🔀	Unknown
Vital Records,	The lay ate has page 2	Completed									24a. Was autop perfor 1 Yes		24b. Were a prior to death?	utopsy findings completion of c	available cause of
<u> </u>	siciar	o Be	25. Was case referred to medical examiner?  1 X Yes 2 No	fospital: 1 ☐ Inpatii	3 <b>V</b> TCD	(0	nt 3□ DO	Othe			(Check only o		. 50		-
ō	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Inju		b. Time of		Bc. Injury Work	at at	rsing Hon	8d. Describe h	ow injur	S □Other (Spe y occurred	icity)	
o	ath. or: After ne funera	atlo	1 XNatural 5 ☐ Pending investigation	(Montin, Da	ly rear)	Injury	М		es 2 🗆 t	No					
Division of	al or Attending Physician: s after death. Il Director: After this certifici id in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, el	jury - At home tc. <i>(Specify)</i>	, larm, str	eet, lactory	, office		2	8f. Location (S City or Tow	Street an m, State	d Number or R )	ural Route Nun	nber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Exami	sician: To the best ner: On the basis of and manner st	ol examination	dge, death and/or in	n occurred a vestigation,	at the tim- in my op	e, date and inion, deat	d place, a	nd due to the o	cause(s) date and	and manner as place, and due	s stated. a to the cause(:	s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	ζ			29c	License	number	-	-	29d. Dat	e signed (Mon	h. Dey, Year)	
			> Unell_						0.C	.M.E		Marc	h 20,	2004	
				ompleted cause of o	death (Item 23	Ba) (Type,		Penr	n Str	eet,	Baltim	ore,	Maryl	and 212	01
	Sta Registi		31. Date liled (Month, Day, Year) MAR 2 4 28	. 0	rar's Signature	B		rack		•					

			1 = For State Registrar	State of Ma	ryland / D	epartr		ealth and		jiene	2004	09221
			1. Decedent's Name (First, Middle, Las	t)			<del>-</del>		2. Date of Dea	th		3. Time of Death
	Physici /Medi Examir	cal	ALBERT AR  4a. Fecility Name (If not institution, give	NOLD street and number)	GERICKE	4b	. City, Town, or	Location of Dea	MARCH th	21 4c. C	Yeer 2004 ounty of Death	4:05 A.I
			MARINER HEALTH	OF FOREST	HILL		FOR	EST HILI		F	HARFORD	
	Funeral Director		212-05-5501	7. Age ☑ M 2☐ F	(In yrs. last birth		Under 1 Year onths Days	If Under 24 Hrs Hours Min	. (Month, Day	Year) 191	9. Birthp Coun 5 Mary	lace (State or Foreign try) land
	Aaryland	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town						10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N	Funeral Director	Maryland Harfo  10e. Street and Number	rd	Ec	dgewo	OCCL Of, Zip Code		1	Og. Citize	n of What Coun	
	3e or	i D	1918 Juniper Ro	ad			2104	40		_	USA	
	deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was			Specify Yes or No- to Ricen, etc.)		. Race - America Black, White,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28s-1 show my injury or other traumatic event, Ira Medical Examinar must be rodified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 □ N	wii		Yes 2 <del>∫</del> Z No	Specify:	to ricen, etc.)	S	pecify:	hite
5-6	natu	ete	15. Decedent's Ed (Specify only highest gra-	ucation de <i>completed)</i>	16a. [	Decedent'	s Usual Occupa of work done	ation during most of wo )	orking	16b. Kind	of Business/Inc	lustry
121	withing and the state of the st	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	<b>+</b> )		vo <i>r use retired</i> Reader	)		Coa	c Elect	ai a Composit
	Hygi Other ent, I	Be Co	17. Father's Name (First, Middle, Last)		Piet	CET L	reauer	18. Mother's Na	me (First, Middle,			ric Company
<u>lan</u>	nould be d Mental narked o	To B	Unknown Unkn	own Geri	cke			Elizab	eth (nmr	n) B	irgel	
Maryland	2 shor		19a. Informant's Name/Relationship (7						ural Route Number			
	and 2 ealth m 27 in		Rosemarie G. Rimm	el / Daugh					ive, Edge			
ore	ges 1 t of H If itel or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ gremation 3 ☐	Removal from State	20b. Place of L cemetery.			l l		20c. Loca	tion - City or To	wn, Stete
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 eny injury or other tr once.		* 4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen		Hilltop	1000		orp. 3-2			n, Mary	
Ba	Depa Impo eny ir		Charles a Es	ugs)					ad, Abing		MD 210	
W. W.	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Pano	needze	Œ			c or respiratory arr		وشاه	Approximate Interval Between Onset and Death Mon / Ko
760,	ate be executed hysicien and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of							
687	physic the b	dicai		d								
P.O. Box 6	that the death certifical ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 24□Pregnant at 19□Unknown	Fetel death		opic pregnancy ner (specify)			230	d. Date of deliver Month	ry Day Year
	quires that n signed b	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in t	the under	lying cause give	on in Part I.				e cause of death?
Records,	sicien: The law requires that the death certificate has been signed by the atter irector, page 2 should be detached for u	ompieted							24a. Was a autops perform	n 2 iy ned? 2 <b>X</b> No	24b. Were autop prior to con death? 1  Yes	osy findings available apletion of cause of
Vital	ysician: The I is certificate ha director, page	BeC	25. Was case referred to medical examiner?					26. Place of De	ath (Check only on			
of V	> 0 0	P	1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inpatier			DOA Othe	4 Nursing F	dome 5 ☐ Reside	ence 6	Other (Specify	)
Division o	To the Hospitel or Attending Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation		Year) 28b. Tir Inji		28c. Injury Work	at ? ∕es 2 □ No	28d. Describe ho	ow injury o	ccurred	
Divi	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.	(Specify)				28f. Location (St City or Town	n, State)		
	he Hosp n 24 hou he Funei pletely fil	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam	vician: To the best of iner: On the basis of and manner state	examination and/	death occ or investi	curred at the tim gation, in my op	e, date and place inion, death occu	e, and due to the caurred at the time, d	ause(s) an ate and pla	d manner as sta ace, and due to	ited. the cause(s)
	with.	Σ	29b. Signature and title of certifier	n	D C		29c. License	number 56607	, 2 ,	9d. Date s	igned (Month, D	Pay, Year)
	1041		30. Name and address of person who of Joseph And	completed cause of de	ath (Item 23a) (T	ype, Print	Sou	th Africa	ood Rel-	BEL	ASR 1	2004 ND 21014
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 4 2004	32. Registra	r's Signature							

ysici		1. Decedent's Name (First, Middle, Last)  Evelyn Joan Gibne.					2. Date of De Month March 1	Day Yeer	3. Time of Death
/ledic amin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of De		4c. County of Dea	
		Union Hospital			Elkton			Cecil	<u>-</u>
eral ctor		213-38-1737-	7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Days		n (Month, Da	17,1939 Ma	thplace (State or Fore buntry) NYLAND
**		Usuel Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Lin
lle 2 a	to	MD Cecil	1	Rising	Sun				1 □ Yes 2 🔯
Boot	lrec	10e. Street and Number	1		10f. Zip Code			10g. Citizen of What Co	ountry?
d last D	ral	311 Montgomery Ro			21911			USA	
event, the Medical Examinet must be notified at	by Funeral Director	11. Marital Status  1 Never Married 27 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cut		(Specify Yes or No arto Rican, etc.)	9- 14. Race - Ame Black, Whit Specify:Whi	e, etc.
CalE		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Business	Industry
Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	lile.	DO NOT use retire	during most of ward)	ronking		
2		12		Bus	Driver	40 Markada N	(Cina Adidale	Public Sc	.hooi
	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
other traumatic ev	T <sub>O</sub>	Roy Wesley Ragan  19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (Stree		V. Foge Rural Route Numb	EMOUL er, City or Town, State, I	Zip Code)
r trau		Bryan A. Gibney/	Husband	311	Montgom	ery Road	l, Rising	Sun, MD 21	911
r othe		20a. Method of Disposition  1 XBurial 2 Cremation 3 F	1	Place of Dispo	sition (Name of matory or other pla	ace)	Date	20c. Location - City or	Town, State
ury o		* 4 ☐Donation 5 ☐ Other (Specify)	R		Cemeter		23-04	Rising Su	
any injury or o		21. Signature of Fineral Service Licens	1. Grod	<u>ie</u> 11	1 S. Que	en Stree	ct, Risin	Funeral Ho g SUn, MD 2	me P.A. 1911
cian lical iner		23a. Pent. Enter the disease, or compl shock, or heart failure. List only of tramediate dause (Final disease or condition resulting in death)	ne causeron each line.	pinon	or the mode of dy	ing, 3001 03 00101	uo or rospiiurory u		Approximate Interval Betwee Onset and Dea
should be detached for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usaars or it jury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.					-	
iched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3[	Ectopic pregnand Other <i>(specify)</i>	су		23d. Date of de Month	livery Day Year
uid be deta		Part II. Other significant conditions con		esulting in the u	nderlying cause gi	ven in Part I.	23e. Did t	tobacco use contribute to Yes 2 ØNo 3 □ Pi	o the cause of death robably 4 DUnkn
rector, page 2 sho	Completed	Vilated ear	ationing fathe	)	7		24a. Was auto pendo 1 Yes	psy prior to death?	utopsy findings avail completion of cause 2 \( \text{No} \)
actor,	Be (	25. Was case reterred to medicat examiner?	decedal.		10		eath (Check only o	one)	
dir	2	1 Yes 2 No	dospital: 1 Inpatient 2	ER/Outpatier 28b. Time o	IL 3L DOA			dence 6 Other (Spe	cify)
CO.	tou	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	ork? ]Yes 2 □ No	200. 200000	now anjury occurred	
funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office	,	28f. Location ( City or To	Street and Number or Ri wn, State)	ural Route Number,
d in by the funera		29a. Certifier 12 Certifying Phy	sicien: To the best of my kr	nowledge, deat nation and/or in	h occurred at the t vestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
etely filled in by the funera		(Check only 2 Medical Exemi	and manner stated.						
completely filled in by the funeral director,	Medical C	(Check only 2 Medical Exemi	and manner stated.		29c. Licen	se number		29d. Date signed (Mont	h, Day, Year)
completely filled in by the funera		(Check only 2 Medical Exemi	and manner stated.			se number		March 19	h, Day, Year)

		•	For State Registrar	State of Ma	ryland /		ment of H				iene	2004	09223
			1. Decedent's Name (First, Middle, I	ast)		0	1			2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		Sherrill	S.		Qu-	tierre	2	1	March	18	2004	7:40A.M.
	Examin		4a. Facility Name (If not institution, g	ive street and number)		41	. City, Town, o	r Location o	of Death		4c. C	ounty of Death	1
			The Johns How	okins Hosp	oital		Baiti	more	2 a-	ty			
	Funeral		5. Social Security Number 6	Sex 7. Age	(In yrs. last b	M	Under 1 Year onths Days	If Under Hours	Min	8: Date of Birth (Month, Day,	Year)	9. Birthp	olace (State or Foreign
	Director		219-48-6878	1□M 2XIF	54	Yrs.	Sillaro Dayo		1	November	10,19	47 Massac	husetts
Ī	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	um or Locati							0d. Inside City Limits
	aryla ehor	2			•	wille	J11						1 X Yes 2 No
	Ba-f	ecto	Maryland Montgo	mery	NOCK		~ 7: 0 :				0		
	with t	Funeral Directo	10e. Street and Number				0f. Zip Code 20850			1'	275	n of What Cour ed Stat	*
	s 234	era	800 Azalea Drive		res in 11 C	12 140			ning (Coo	-4. V No		. Race - Americ	
	er de Item	U.	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🔀 No		If Ye	s, specify Cuba	an, Mexican	n, Puerto R	cify Yes or No- Rican, etc.)	14	Black, White,	
50	rs aft	by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		10	Yes 2∑No	Specify:			S	ресіту: Whi	ite
3	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28a-f ehow ent, "Lie Mudical Examiner must be notified at		15. Decedent's		16	a. Decedent	's Usual Occup	ation			l6b. Kind	of Business/Inc	dustry
	in 72	Completed	(Specify only highest of	rade completed)		(Give kind life. DO	s Usual Occup f of work done o VOT use retired	during most	t of workin	g			,
7	with iene	E	Elementary/Secondary (0-12)	College (1-4or 5+)	)	Sa1	es Mana	gemen	t		Fra	grance	
3	othe ent.	BeC	17. Father's Name (First, Middle, La	st)				_		(First, Middle, A	laiden Su	ımame)	
2	ould be filed with Mental Hygiene. arked other the atic event, the	To B	Kenneth S. Hant	en				S	hirle	ey J. Ba	rt1e	tt	
2	2 should I and Men Is marke aumatic		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing A	ddress (Street	and Numbe	er or Rural	Route Number,	City or T	own, State, Zip	Code)
Ž	Health a tom 27 ls		Kenneth S. Hant	en/ father	7	805 R	enoir C	ourt	Potom	nac, Mar	y1an	id 20854	ł
<u>5</u>	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f ehow or other traumatic event, it is Mudical Examiner must be multiped at		20a. Method of Disposition		20b. Place	of Disposition	n (Name of ry or other plac	ce) N	March	ate 23	0c. Loca	tion - City or To	wn, State
Ē	Pages nent of int: If it		1 🌠 Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spe		Gate	•			004		Silv	er Spri	ng
Dallimor	permit. Pages Department of Importent: If I any injury or once.		21. Signature of Funeral Service Lic		100803	Roc Roc	me and Addres	ss of Facilit Inc. Mary	y Rob	ert A. West Mo	Pumpl ontgo	nrey Fur mery Av	neral Home/ venue
g.			23a. Part1. Enter the disease, or co	mplications that cau ed the	ne death. Do								Approximate Interval Between
	Physician		shock, or heart failure. List on Immediate Cause (Final	ny one cause on each line	2 Do	100	E.L.	00					Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	9 of):	Taul	NE	-				2 dails
	Examiner			System	ir To	Star	most	NU I	Reso	mse.	Ciny	Jamo	Fdais
96		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	of):		)	1		3.7		
	cuted	Examiner	that initiated events	· Bladd+	er Co	unce	~ WI	thi	neta	astas	5		1 year
Ç	a exe		resulting in death) Last	Due to (or as a	consequence	e of):							9
00/0	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Ical		d									
Ö	n requires that the death certifics been signed by the attending pt should be detached for use as t	Wed	IF FEMALE:										
Š	ith ce tendi	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		th 3□Ect	opic pregnancy	,			230	d. Date of delive	*
	e dea	sici	in the past 12 months?	4∏Pregnant at ti 9∏Unknown	me of death	5 ☐ Ot	ner (specify)					Month	Day Year
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ń	es th igner	þ	Part II. Other significant conditions	contributing to death but	not resulting	in the unde	lying cause give	en in Part I.		1 1/			ne cause of death?
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		Con								1 Yes 2	led? □ No	death?	2) No
N II G	Physician: r this certificated director, iral	Be	25. Was case referred to medical examiner?						of Death	(Check only one	)		
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	ing P	ii o	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Yeer) 28b.	Time of Injury	28c. Injun Worl			Bd. Describe ho	w injury o	ccurred	
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<u> </u>	or At fter d yirect n by	Certification:	4 Homicide determine		y - At home, f (Specify)	farm, street,	factory, office		28	If. Location (Str. City or Town	eet and N State)	lumber or Rurai	I Route Number,
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	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the best of aminer: On the basis of e and manner state	xamination a	ge, death oc ind/or invest	curred at the tim gation, in my o	ne, date and pinion, deat	d place, an th occurred	nd due to the ca d at the time, da	use(s) an te and pla	d manner as sta ace, and due to	ated. the cause(s)
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	10		20 Name and address of second	a completed	7-20	· CTues D	10	C.2	4	) !!	(VY)	01/18	12004 NOVE MD 28=
	W		30. Name and address of person wh	The Mine L	Lo Or XAS	Howard	- C	6011	North	Wolfe	(+	Ratio	MD
	Sta	te	31. Date filed (Month, Dey, Year)	A 32. Registrar	s Signature	11001	4,		.0.()	1 1011	>1	J MUNI	WC 2128-
	Registr		MAR 2 4 2004	Regul A	K A	ode							
			MULL N T FOOT	4	- 5								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Reg. No 2 0 0 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year HARRISON MAURICE 2004 DENJAMIN MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DRINCE REGIONAL HOSPITAL ALIRE Georges aurel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 100 M 2□F 220-64-5182 MD Director Usual Residence of Decedent 10c. City, Town or Location Fredericksburg the Maryland 10a. State 10b. County 10d Inside City Limits or 28a-f show other traumatic event, the Madical Examiner must be notified at <del>S</del>potsylvania VA FREDERICKSPURG 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with US4 10914 akeland Wax 22407 or Items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "naturel", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Financial Advisor 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hyrs inance 2th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hamsor Bertha Gallaway Saac 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lakeland Way Fredricksburg arletta Harrison WIFE 6914 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō **≒ 5** 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny injury or once. trlington □Donation 5 □ Other (Specify) permit. 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICES 21. Signature bi Funeral Ferris III ns. 5151 BALTIMORE NATIONAL PIKE BALTIMORE MD 21229 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, many, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (unas a consequence of) Completed by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Day Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 2 🗆 No 3 🖂 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital or Attending Physician: hours after death.

Ineral Director: After this certific
y filled in by the funeral director. 25. Was case referred to medical examiner?
1 X Yes 2 ☐ No Be 26. Place of Death (Check only one, Hospital: 2 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation 2 No М 1 ☐ Yes 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a To the Funeral D 1\_\_Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 238 Cartifion completely 1 (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MARCH 30. Nati and address of person who completed cause of

Registrar

State

31. Date filed (Month, Day, Year)
MAR 2 4 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 09225 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** March 18, 2004 Ruby Pickrel 8:10 PM Jackson Hunley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glade Valley Nursing Home Walkersville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F Yrs. 224-03-8536 85 1918 Virginia Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 ∀Yes 2 No MD Walkersville Directo Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 56 West Fredrick 21793 Street USA filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No \$ Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ring most of working Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home item 27 is marked other other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Turner Willis Pickrel Maude Simpson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda J. Williams - Daughter 112 Shore Lane Fairfield Glade, TN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages '
Department of F
Important: If ite
any Injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Green Hill Cemetery 3-22-04 Altavista, VA 4 ☐ Dorlation 5 ☐ Other (Specify) 22 Name and Address of Facility Finch & Finch, Inc. 21. Signature of Funeral Service Licencee Perf. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 809 Main Street Altavista, VA Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's Dementia **Physician** 5 Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Cther (specify) Division of Vital Records, P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rmed? 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending To the Hospital or Attentions within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifles 29c. License number 29d. Date signed (Month, Day, Year) D35183 March 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 W. 9th St. Frederick, MD Afrookteh, MD Ali 52. Registrar's Signature 31. Date filed (Month, Day, Year, MAR 2 4 2004 Registrar

			For State Registrar		State o	f Marylar	nd / Depa <i>Cei</i>	artment of H	lealth a Death	and M	lental Hy	giene Reg. No	2004	097	226
			1. Decedent's Name (First,	Middle, La	st)						2. Date of De	ath Dav	y Year		of Death
	Physici		William Arde	ll Hu	mmel						March_	18		1 1 • 1 9	3 A M
	/Medio Examir		4a. Fecility Name (If not ins					4b. City, Town, or		of Death			County of De		
			Franklin Sq	uare	Hospita	1		Roseda	ale				Bal	timore	
	Funeral Director		5. Social Security Number 215-66-3069		ex M 2□F	7. Age (In yrs.	last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 19	th ly, Year) 195	9. Bi	nthplece (Stete country) yland	e or Foreign
250			Usual Residence of Decede	ent											
	ahow ad at	. [	10a. State 10b. C	ounty		10c. Ci	ty, Town or Lo	cation						10d. Inside	
	a-f a	cto	MD Bal	Ltimo	ce	Bal	Ltimore							1014	es 2 No
	with the	Funeral Director	10e. Street and Number 4114 Taylor	Avenu	e			10f. Zip Code 21236					izen of What C ced Sta	-	
	leath na 23	era	11. Marital Status		12. Was Dece	edent Ever in U	J.S. 13. 1	Was Decedent of H	ispanic Ori	igin? (Sp	ecify Yes or No	)-	14. Race - Am		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23e or 28e-f ahow my injury or other traumatic event. Ite Mudical Examina must be notified at ONCE.	۵	1 ☐ Never Married 26		Armed For 1 Tyes If Yes, Give Year or D	2 <b>⊡</b> No ve		f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specity:		Rican, etc.)		Black, Wh Specify: Whi		
ŏ	2 hor	ted		cedent's E			16a. Dece	dent's Usual Occup	ation	et al work	ina	16b. K	ind of Busines	s/Industry	
Baltimore, Maryland 21215-0036	within 7 ane. then "n	Completed	Elementary/Secondary (0		College (	-	Vendi	kind of work done of DO NOT use retired	d)	N OF WORK	ii ig	Hosp	oitalit	У	
7	filed Hygie ther	ပ္	17. Father's Name (First, M	liddle, Last,	)		101142	9	18. Mothe	er's Nam	e (First, Middle	, Maiden	Sumame)		
lan	ld be ental ked o	To Be	William Arde						Betty	y May	Rober	ts			
Z Z	2 should and Men Is marke	-	19a. Informant's Name/Re	ationship (	Туре, Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rur	al Route Numb	er, City o	r Town, State,	Zip Code)	
Ž	alth a		Mrs. Donna H	ummel	/Wife		4114	Taylor Av	renue	, Ba	ltimore	, MD	21236		
ore,	of Herof		20a. Method of Disposition	ation 3	Pemoval from		Place of Dispo cemetery, crei	sition (Name of natory or other plac	(e)		oate ar 22	20c. Lo	ocation - City o	r Town, State	4
Ĕ	Page tment tant: It		' 4 □ Donation 5 □ Ot	her (Specif	y)		20.00	ke Cremat	_	2	004		sville	, MD	
Bai	permit. Departi Importi any inj		21. Signature of Funeral S	Hul	W	M0098	to 23	Name and Address Cremation 3717 Gree	and and n Pas	Fune ture	ral Alt s Drive	erna Ba	tives ltimor	e, MD	
- 10			23a. Part1. Enter the diseashock, or heart failure	ase, or com b. List only	plications that one cause in e	caused the dea	th. Do not ent	er the mode of dyin	g, such as	cardiac	or respiratory a	rrest,		Approxim Interval E Onset an	Between
	Physician		Immediate Cause (Final disease or condition		a. 1	Terros	cleriti	( Caroli	e Vos	cuto	- Vi	5-Co	Le	Onset an	u Death
	/Medical Examiner	П	resulting in death)	(	Due to	(or as a consec	quence of):								
8	Par .	-	Sequentially list conditions		b. Due to	(or as a consec	quence of):								
$\bigcap$	ted nsit	Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events	≺		(	,								
13	al-tra	xar	that initiated events resulting in death) Last		C. Due to	(or as a consec	quence of):								
8760,	icate be executed physician and s the burial-transit	dical		·	d										
9	tificat ng phy as th	Medi	15 551441 E												
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σ.	that the de led by the detached	y Ph	Part II. Other significant c	onditions	-	eath but not res	sulting in the u	nderlying cause giv	en in Part i		23e. Did	tobacco i	use contribute	to the cause o	of death?
rds	quires on sign	q pa			<i>†</i> :						10	Yes 2	□No 3□F	robably 4 [	□Unknown
တ္တ	aw re s bee 2 sho	Completed									24a. Was		24b. Were a	autopsy finding	s available
æ	The la	E O									perfo	psy ormed? 2 \(\sum \) No	death?		I Cause of
ita	ian: rtifica stor, p	0	25. Was case referred to n	nedical					26. Place	e of Deat	h (Check only				
<b>*</b>	nysic als ce direc	To B	examiner? Yes 2 □ No		Hospital: 1 🗆	Inpatient 21	ER/Outpatier	nt 3 DOA Oth	er: 4 □ Nu	ursing Ho	me 5□Resi	dence	6 □Other (Sp	ecify)	
0	ng Ph iter th neral		27. Manner of Death  Danatural 5 □	Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	28c. Injun Wor	y at k?		28d. Describe	how injui	y occurred		
<u>.</u>	ttendir death. ctor: Ay y the fu	atle	2 Accident	investigatio				M 1 🗆	Yes 2	No					
Division of Vital Records, P.O.	or Att after de Direct in by t	Certification;	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined	289. Place	e of Injury - At h ing, etc. <i>(Speci</i>	nome, farm, str ify)	eet, factory, office			28f. Location ( City or To			Rural Route No	umber,
	To the Hospital or Attending Physician: The law requires that within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	edical C	(Chack only 2 XM		miner: On the b			h occurred at the tin vestigation, in my o							∋(s)
	thin S the the	Med	29b. Signature and title of	certifier _	anu man	mier stateu.		29c. Licens	e number			29d. Da	te signed (Mor	nth, Dey, Year	)
	7. ₹ ₹ 8		XXL	lo	114				C.M.I	₹			rch 18,		
	12		30. Name and address of p	person who	completed caus	se of death (Ite	m 23a) (Tvpe			- •		1 101.		2007	
	1/		J. LARON	LOS	KEIN	10	111 P	enn Stree	et, Ba	altin	nore, M	aryl	and 212	201	
	Sta Regist	ate rar	31. Date filed (Month, Day,	Year)	32. F	Registrar's Sign	ature	4	park		·				
10	negist	ell.		MAR 2	4 / 11 4	And the	Range	10 De	Dack!	2					

		Please	State of Maryla	and / Dep	artment of H	lealth and N			ole. 04 09227
		Registrar  1. Decedent's Name (First, Middle, La	ati	Ce	rtificate of	Death	2. Date of Dea	Reg. No.	3. Time of Death
Physic /Med		Rosemont Iren	e Holland				03/19	/2004	1:25A M
Exami	ner	4a. Facility Name (If not institution, giv				or Location of Death		4c. County	
F		300 Cloverhil  5. Social Security Number 6.5		rs. last birthday	Pasade If Under 1 Year		8. Date of Birt	b	Arundel  9. Birthplace (State or Foreign
Funeral Director			<sup>™</sup> 2 <b>E</b> F 76	Yrs.	Months Days		01/05/	1928	Birthplace (State or Foreign Country)     M.D
anyland show	7	10a. State 10b. County		City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
the N	ecto	MD Anne A	rundel   1	Pasade	n a 10f. Zip Code			10g. Citizen of W	
3a or	ō	300 Cloverhil	1 Road		2112	2		U.S.A	,
death	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		- American Indian,
in 72 hours after death with the Maryland in 72 hours after death with the Maryland "natural", or Items 23s or 28s-f show tedical Examiner must be redified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No		rican, etc.)	Specify:	white, etc. White
72 hours aff	eted	15. Decedent's E (Specify only highest gra		16a. Dece	ident's Usual Occup	pation during most of work	kina	18b. Kind of Bu	siness/industry
within 72 ene. then "nei	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire e Maker	during most of work d)		Own :	Ното
8 6 9 7	ပ္ပိ	17. Father's Name (First, Middle, Last	)	пош	e Maker	18. Mother's Nam	ne (First, Middle,		
od la b	To Be	Frederick Duns					e Scha		-/
shour man	-	19a. Informant's Name/Relationship (		19b. Mail	ing Address (Street	and Number or Rui			State, Zip Code)
C = W =	Ì	Darlene Snyder				hill Rd.	,Pasad	ena,MD	21122
P to H		20a. Method of Disposition 1 Durial 2 Cremation 3 D	Removal from State	<ol> <li>Place of Disp cemetery, cre</li> </ol>	osition (Name of matory or other pla	ce)	Date	20c. Location - (	City or Town, State
Pag ment tent:		`4 □Donation 5 □ Other (Special	y) Ba			ory 03/2		Baltim <sub>e</sub>	
parmit. Pages 1 ar Department of Hea importent: If tiem any injury or othe once.		21. Signature of Funeral Service Lice	nsee						ral Home, PA
		23a. Part1. Enter the disease, or com	plications that caused the d			iera Dr. no. such as cardiac			Z I I Z Z  Approximate
Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Metasta  Due to (or as a cons	Li C	lung	Cancer			Interval Between Onset and Death
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The law requires that the death certificate are has been signed by the attending physicage 2 should be detached for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	⊒Ectopic pregnanc ⊒ Other (s <i>pecify</i> )	у		23d. Date Mon	e of delivery th Day Year
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w require been sig should by							1 <b>3</b> Y	es 2□No	3 ☐ Probably 4 ☐ Unknown
awre awre 2 sho	Completed						24a. Was a		Vere autopsy findings available
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hysician: The law his certificate has b	Be (	25. Was case referred to medical examiner?				26. Place of Deat			
Physic this c	2	1 Yes 2 No	Hospital: 1 Inpatient 2		III 3 DOA			lence 6 Othe	
for Attending Physician: The law requirest after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation		28b. Time (	Wo	ryat rk? ]Yes 2 □ No	28d. Describe h	low injury occurre	ed
al or Alt s after de li Direct	Sertific	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	t home, farm, st ecify)	reet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
To the Hospital or Attending Physician: To the Hospital or Attending Physician: Within 24 hours after death. To the Funerel Director: After this certificat completely filled in by the funeral director;	Medical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, dea ination and/or in	th occurred at the ti	me, date and place, opinion, death occur	and due to the cred at the time, c	cause(s) and man date and place, a	nner as stated. nd due to the cause(s)
To th Withir To th comp	Me	29b. Signature and title of certifier			29c. Licens			_	(Month, Day, Year)
Α		Vi grille	sur on on. o.		04	2820		Marile	20,2004
0		30. Name and address of person who Chart to phen (	teBORTA M.D	. 3708		AIN Rd.	PASAdo		
St	tate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	low VI				

			Flease	State of Ma				Health and Me	•	•	
			1 - For State Registrar	State of Ivia	ai yiai iu		rtificate of			g. No. 200	1 19228
			Decedent's Name (First, Middle, L.	ast)			inouto or		2. Date of Death	g. 140.	3. Time of Death
	Physici		Nellie	Marie		Но	ffman	,	Month	Day Year	4 2:55A M
	/Medic Examin		4a. Fecility Name (If not institution, gi	ve street and number)				or Location of Death	, , , , , , , , , , , , , , , , , , , ,	4c. County of Dee	
	_ xaiiiii		Charleston	NTM			150/t	- imore		Balte	more
	Funeral				e (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, June 14	Year) 9. Bir	thplece (State or Foreign ountry)
₩. <	Director		217-22-9976	1UM 2ELF   88	8	Yrs.			June 14	, 1915 Ma	ryľand
	and w		Usuel Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation				10d. Inside City Limits
	Mary	ō	Maryland Baltimo	re	Cat	onsv	i 11e				1 Yes 2 No
	r 28a	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	ountry?
	be filed within 72 hours after death with the Maryland Hygiene. d other than "naturel", or items 23a or 28a-f show event, the Mulical Examinar must be notified at	aj D	709 Maiden Cho	ice Lane, A	Apt #8	3203	21228	3		USA	
	ems er m	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of H	Hispanic Origin? (Spec an, Mexican, Puerto R	rfy Yes or No-	14. Race - Am Black, Whi	
0	or it	by F.	1 Never Married 2 Married	1 Tes 2 14 1 If Yes, Give			1 ☐ Yes 2 ☒ No		, , , ,		White
	within 72 hours after ene. than "naturel", or Ite he Medical Expinite		3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		16a Daga	dent's Usual Occur				n-de-se-
'n	in 72	ojet	(Specify only highest g	rade completed)		(Give		during most of working	9 '	6b. Kind of Business	vindustry
7 7	e filed within Il Hygiene. other than vent, I'le Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Но	omemaker			Own Home	e
<u> </u>	be filed ital Hygi id other event, I	Bec	17. Father's Name (First, Middle, Las	•				18. Mother's Name	First, Middle, M	laiden Sumame)	
/land		To	George	F.	Henry			Susan		Slad	le
Mar)	0 0 - 6		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number or Rural	Route Number,	City or Town, State,	Zip Code)
-	12 g g		Frances J. Busic	k (Stepdaus							
0	Pages 1 ar		20a. Method of Disposition 1258 Burial 2 ☐ Cremation 3	☐Removal from State	cem	netery, crer	sition (Name of matory or other pla			Oc. Location - City or	
Saitimore	t. Pa ntmen ntent: njury		`4 □ Donation 5 □ Other (Spec		Lorr		Park Cem		3/04 W	oodlawn, N	Maryland
na Da	permit. Pages Department of I Important: If It any injury or o		21. Signature of Funeral Service Lice	insee			2. Name and Addre	ro		rk Funeral	
en.	-		23a. Part1. Enter the disease, or cor	nplications that caused	the death.			ens Ave.,			229 Approximate
	Obvoision		shock, or heart failure. List ont Immediate Cause (Final	one cause on each lin	ne.	1	1		,,	•	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due lo (or as	a consequer	nce of):	a dis	ease			years
	Examiner										
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	nce of):					
	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
/bg/	te be executed ysician and he burial-transit	cai E		Due to (or as	a conseque	nce or):					
280	phys phys s the			_ d							
X	certifica nding ph	hysician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnanc	y .				23d. Date of de	livery.
ň	death e atter ed for u	ciar	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify) _	У		Month	Day Year
5	the che	hys	9 ☐ Unknown	9□ Unknown					,		
, L	requires thet een signed b nould be deta	by P	Part II. Other significant conditions	contributing to death be	ul not resulti	ng in the u	nderlying cause giv	ven in Part I.	23e. Did Joba	acco use coninbute to	the cause of death?
cord	w require been si should I	ted							1 Tes	2 □ No 3 □ P	robably 4 Illuknown
d)	2 sl	ompieted							24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	ate pag	Con							perform	ed?   death?	2 □ No
VItal	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0.1	26. Place of Death	Check only one	)	
5	this aldi	To To	1 ☐ Yes 2 ☐ Ho  27. Manner of Death	1 Inpatie		VOutpatier  8b. Time of	nt 3□DOA Oth	4 Narsing Home		nce 6 Other (Spe v injury occurred	city)
0	ding Phy lh. After thi funeral	tion:	1 Natural 5 Pending 2 Accident investigate	(Month, Day	y Yeer)	Injury	Wor	rk? Yes 2 No	id. Describe not	v injury occurred	
DIVISION	el or Attending F s after death, it Director: After d in by the funera	ertificati	3 ☐ Suicide 6 ☐ Could not	ha	ury - Al hom	e, farm, str	eet, factory, office		f. Location (Stre	et and Number or R	ural Route Number,
5	el or s afte s Dire	Cert	4 Homicide	building, etc	c. (Specity)				City or Town,	State)	
	ospit hour unere	cal	29a. Certifier 1 Certifying P	hysician: To the best	of my knowle	edge, deatl	n occurred at the tir	me, date and place, an	d due to the car	use(s) and manner as	s stated.
	To the Hospitel o within 24 hours aft To the Funeret Di completely filled in	Medical	one)	and manner sta	ated.	. and or in					
	To To	Σ	29b. Signature and title of derivier	17	724		29c. Licens	e number		d. Date signed (Mont	
	it		I W	W	MND		DY	1009		Yarch 19	1,2004
	10		30. Name and address of person who	completed cause of d		3a) (Type,	1	eLane	RIL	M men	7,2004 D 21228
	Sta	te	31. Date filed (Month, Day, Year)	2. Registr	ar's Signatur		1 010/0	Lame	, Dull	11101611	× = (== b
	Daniel		MAR Z 4 ZU	14	22	· Alexander	. M				

			1 - For State Registrar	State of	Marylar	_			ealth a Death	and M	ental Hy	giene Reg. Na	201	) 4	0922	2 0
			1. Decedent's Name (First, Middle, La	st)		•	_				2. Date of D			9 <b>6</b> r	3. Time of Deat	h
	Physici /Medio		Beatric	e C. Ha	wk					IM.	larch		2004	961	1:45A	М
**	Examin		4a. Facility Name (If not institution, given	re street and num	ber)		4b. Cit	, Town, or	Location of	of Death		40	. County of	Deeth		
				Ave.				ltim	ore	0411			N/	Α		
ŀ	Funeral Director			6ex 7 1□M 2X□F	. Age (In yrs.	last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D Dec 1	8, 193	9	Birthpla Count VI	ace (State or Fore	aign
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	ocation				<u></u>			10	d. Inside City Lin	nite
	Maryla	tor	,	N/A		.,,		Ba	itimore					10	1 Yes 2	
	3s of 28s	i Direc	10e. Street and Number 921 Augusta Ave.				10f. Z	p Code	2122	29		10g. Ci	tizen of Wha	J.S.A.		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Modical Examinational Le notified at 800ce.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marned 3 2 Widowed 4 Divorced	12. Was Deced Armed Ford 1  Yes 2 If Yes, Give Year or Dat	es? ! 🗷 No		Was Dec If Yes, sp	ecify Cuba	spanic Origin, Mexican	gin? (Spe , Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Black, ' Specify:	White, e		
Maryland 21215-0036	within 72 ho one. than "natur	mpieted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		4or 5+)	16a. Dece (Give life.	kind of w	ork done d use retired	furing most		ng	16b. k	ind of Busir	Home	•	
land 2	ld be filed v ental Hygie ked other i Ic event, II	To Be Co	12 17. Father's Name (First, Middle, Last Robert	Lockett					18. Mothe	r's Name	(First, Middle He	, <sub>Maider</sub> len V	Sumame) Villiams			
	nd 2 shou alth and M 27 is mar r traumat		19a. Informant's Name/Relationship (	Type, Print)							Route Numb Maryland			ite, Zip (	Code)	
Baltimore,	Pages 1 and ment of Headers I it is the mury or other		20a. Method of Disposition 1			Place of Disponentery, crea	matory or	me of other place morial F			ate 03/22/04	20c. L	ocation - Cit Balti	y or Tow	The second second	
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Lice	nsee	`.	22	2. Name a	nd Address step B 300 Eu	s of Facilit rothers Itaw Pla	Funera	al Home F	P.A. MD 21	217			
-	Physician /Medical Examiner sthe parial-transit	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consecuration of the co	quence of):	ter the mo	de of dying	g, such as	cardiac or	respiratory a	arrest,			Approximate Interval Between Onset and Death	1
Division of Vital Records, P.O. Box 68760,	The law requires that the death certificate be age has been signed by the attending physicia page 2 should be detached for use as the buri	Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 ☐ Feta nt at time of o	al death 3	]Ectopic   ] Other (≤						23d. Date o Month		y Day Year	
rds, F	w requires tha been signed should be del	þ	Part II. Other significant conditions		th but not res	sulting in the u	nderlying	cause give	en in Part I.		\ \ \				cause of death?	
al Reco	ilcien: The law requ certificate has been rector, page 2 shoule	Completed									24a. Was auto perfe		dea	e autops r to com th? Yes 2	sy findings availa pletion of cause	ble of
Žį.	ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:				0#		of Death	(Check only	one)				
o	Phys this al dii	. To	1 Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatier			4 🗀 Nu		ne 5 Res 8d. Describe			Specify)		
lon	Attending or death. ector: After by the funer	ation	1 ☐ Natural 5 ☐ Pending investigation	(Month	Day Year)	Injury	м	28c. Injury Work	:?` ∕es 2 ⊡t		00. 00301100	now inju	ry occurred			
Divis	ef or Attences after death	Certification:	3 Suicide 6 Could not be determined	288. Place 0	f Injury - At h g, etc. (Special	ome, farm, str fy)	reet, facto	y, office		2	8f. Location ( City or To	Street ar wn, State	nd Number o	or Rural i	Route Number,	
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier (Check one) 2 Medical Cxa	nysician: To the base priner: On the base and manne	is of examina	owledge, death ation and/or in	h occurred vestigation	al the tim	e, date and pinion, deal	d place, a	nd due to the d at the time,	cause(s date and	and manne d place, and	r as stat	ted. he cause(s)	
	To the Comp	Ň	29b. Signature and ville of certifier	1			29	c. License	number	_			te signed (A			
7	1		) // m//c	// 				05	1063	)		Ma	105 18	2	204	
	5		30. Name and address of person who 22 5. Greek			n 23a) (Type,		, M	D 2	120	) (		1			
	Sta Registi		31. Date filed (Month, Day, Year)  MAD 9 4 2004	32. Re	gistrar's Signa	ature	80									

		,	1 - For State Registrar		State of Ma	arylan		artmer <i>tificat</i>			nd Mental		ene 2 (	004	09230
	Physici		1. Decedent's Name (First LEMUE	, Middle, Last,	4166				_	***	2. Date of Month		Day	Year	3. Time of Death 1:07a
	/Medio Examin		4a. Facility Name (If not in Sinai Ho	spital		e (la vre	last birthday)			Location of D imore If Under 24	Death		4c. County		
	Funeral Director		214-16-5732 Usual Residence of Dece	2 1	M 2 F	81	Yrs.	Months			Min. (Monti	7, Day, 7 2–23	(ear)	S.C.	ace (State or Foreign try)
	death with the Maryland rme 23a or 28a-f ehow rmust be notified at	_		County		10c. City	y, Town or Lo							10	Od. Inside City Limits
	he Ma	ecto	Md.  10e. Street and Number	NA			Balti		0-1-			10.	Chi	45.40	X□Yes 2□No
	with 1	IDI		**	1.4			10f. Zip		1215		109	, Citizen of V USA	vnat Coun	.ry r
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 Ie marked other than "natural", or Iteme 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral Director	4017 Libert  11. Marital Status  1 Never Married 2  3 □ Widowed 4 □ D	☐ Married	12. Was Decedent I Armed Forces? 1 Tyes 2 Th If Yes, Give X Year or Dates:			Was Dece f Yes, spe	dent of His cify Cubar		n? (Specify Yes of Puerto Rican, etc	or No-	14. Rac	e - America ck, White, e	etc.
200	72 hou natura lical E	ted	15. D	ecedent's Edu highest grad	cation		16a. Deced	lent's Usu	al Decupa	tion uring most of	f working	16	ib. Kind of Bu		
21215-0036	filed within 7 Hygiene. other than "r ent, the Med	Completed	Elementary/Secondary 9th grade	(0-12)	Coltege (1-4or 5	i+)	life. I	<i>วิธีหังไร้</i> นี gshoเ	se retired) ceman				STA		
Maryland	of other	Be	17. Father's Name (First, I Stephen	Middle, Last)		Hi	11			18. Mother's Irene	Name (First, Mi	ddle, Ma	Wrigh		
N Z	should and Men le marke eumatic	우	19a. Informant's Name/Re	elationship (Ty	rpe, Print)		19b. Mailin	g Address	S (Street a		or Rural Route N	u <i>mber, C</i>			Code)
	1 and 2. Health a em 27 le		Delois Reed		Sister		437	Will	liams	towne	Ct. , M	ille	rsvill	.e, Mo	21108
Baltimore,	Pages 1 and the part of He part: If Item		20a. Method of Disposition  1 Burial 2 Crem  4 Condation 5 C	nation 3 🗆 F			lace of Dispo emetery, cren butus		_	1	Date -24-04		c. Location - rbutus	_	
Balti	permit. DepartmImports any inju		21. Sonature of Funeral S	Service Licens	Walters	In	22	. Name ar	nd Address	s of Facility  East	1101		imore North		21202
),	Physician be executed by sicial and physician and physician and physician strangers with the partial fluorest physician and phys	Examiner	23a. Paff1. Enter the dise speck, or heart failui Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s, List only of	Due to (or as	hm) a consequ	uence of):	er the moo	de of dying	, such as car	rdiac or respirato	ory arrest			Approximate Interval Between Onset and Death
P.O. Box 68760,	death certif e attending nd for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregrin the past 12 month 1 Yes 2 No 9 Unknown	s?	d	2 Fetal time of de	death 3	Ectopic pi	pecify)				23d. Dat Moi	e of deliver	y Day Year
	sign sign	by	Part II. Other significant of		Well W	t not rest	ulting in the ur	nderlying o	ause give	n in Part I.					e cause of death?
Vital Records,	The law ate has b page 2 si	Completed									-   :	Was an autopsy performe es 2∫	d? 5	rior to com leath?	sy findings available pletion of cause of
Zit:	eicien: Th certificate irector, pag	o Be	25. Was case referred to examiner?  1 Yes 2 No		lospital:	054	ER/Outpatien		Other		Death (Check o				
Division of	ting Ph n. After th funeral	$\vdash$	27. Manny of Death	Pending investigation	28a. Date of Injur (Month, Day	v	28b. Time of tniury		28c. Injury Work	4 U NUISII			injury occurr	er <i>(Specify)</i> ed	
Divis	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	Certification;	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injubulding, etc.	ury - At ho	ome, farm, stre	et, factor	y, office			on (Stree r Town, S		er or Rural	Route Number,
	he Hospit n 24 hour he Funere pletely filk	edical	29a. Certifier 1 C (Lheck only 2 N	ertifying Phy edical Exami	sician: To the best oner: On the basis of and manner sta	examinat	wledge, death tion and/or inv	occurred restigation	at the time, in my opi	e, date and p inion, death o	place, and due to occurred at the ti	the caus	se(s) and ma and place, a	nner as sta and due to	ted. the cause(s)
		Σ	29b. Signature and title of	certifier	und			290	D 3	number 3 9 1 2	27		Date signed		
_	~ ~		30. Name and address of 52-A-A H M	ED	821 N. E	ella	w ST	Print)	line	8EQ 14	10 2/20	1			
	Sta Registr		31. Date filed (Month, Day	( Year) 4 200.	327 Registra	ar's Signat	- 4	All F							

			1 - For State Registrar	State of M	aryland	d / Depa		of H	ealth a		ental Hy	giene	200	4 092:	3
<b>)</b>	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last L. M. E. R	street and number)		- A 1			Location o	f Death	2. Date of De Month 93	Day 2 C	County of De	4 4:30 1	th D M
<b>*</b> €1.	Funeral Director		5. Social Security Number  212-20-6594  Usual Residence of Decedent			ast birthday) Yrs.	If Under 1		If Under 2 Hours		8. Date of Bir (Month, Da 12-10	rth ay, Ye <i>ar)</i> 0-25	NA 9. B	irthplace (State or Fo Country) Md .	reign
	he Maryland 8a-1 show culfied at	ector	Md. 10b. County NA		10c. City	Town or Lo	more					10.00		10d. Inside City Li	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If itsm 27 is marked other then "natural", or itsms 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1500 Cliftview At  1. Marital Status  1 Never Married 257 Married  3 Widowed 4 Divorced	Je.  12. Was Decedent Armed Forces  1 Tyes 2   If Yes, Give Year or Dates:	?	1	Nas Decede f Yes, specif	21 ont of His fy Cubar		in? (Spec Puerto R	cify Yes or No lican, etc.)		Black, Wi	nerican Indian,	
Maryland 21215-0036	e filed within 72 ho il Hygiene. other than "natur vant, the Madical I	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last)		5+)	(Give	dent's Usual kind of work DO NOT use	done di retired)	u <i>ring</i> most Trans	sport	g ation (First, Middle	CS	ind of Busines  X Rail  Sumame)	,	
larylar	2 should be and Mental Is marked o	ToB	Elmer  19a. Informant's Name/Relationship (7)	Levi rpe, Print)		Handy		Street a		ldre		er, City o	Lee	Zip Code)	
Baltimore, M	Pages 1 and 3 nent of Health int: If itsm 27 iry or other tri		Alva Handy  20a. Method of Disposition  1 1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)		CB	1500 ace of Dispo metery, cren rison	sition (Name natory or oth	of or place	)		altimo	20c. Lo	ocation - City o	1213 or Town, State	
Balti	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licens  L Que	, wa	nes		Name and			D	altimo	re,		1202	
760,	Physician /Medical Examiner portion and portion and portion provided the provided t	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as  Due to (or as  Due to (or as	a conseque	ence of):		of dying	, such as d	ardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Deat	
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3□	Ectopic pred					-	23d. Date of d Month	elivery Day Year	
ords, P	w requires that been signed b should be deta	b	Part II. Other significant conditions con END STAGE					ise giver	n in Part I.			obacco u Yes 2[		to the cause of death	
tal Reco	an: The law r tificate has be tor, page 2 sh	e Completed	25. Was case referred to medical						26 Place	of Death	24a. Was autop perfo 1 Yes	osy ormed? 2 No	prior to death?	autopsy findings avail completion of cause s 2 No	able of
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To B	examiner?  1	28a. Date of Inju (Month, Da	iry y Year)	ER/Outpatien 28b. Time of Injury	M 286	Other C. Injury: Work?	4 ☐ Nur	sing Hom 28	e 5 ☐ Resi	dence (how injur	d Number or F	ecity) Rural Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical Co	29a. Certifier (Check only one)	sician: To the best ner: On the basis o and manner st	of examination	vledge, death on and/or inv	occurred at restigation, in	the time	e, date and nion, death	place, ar	nd due to the d at the time,	cause(s) date and	and manner a place, and du	is stated. le to the cause(s)	
)	To th withir To th	Me	29b. Signature and title of certifier	akune	w, 20	1 D		License	number 800	9			e signed (Mor	oth, Dey, Year)	
	M		30. Name and address of person who con ZELALEM MAICO	NNEN 5	601 6	-D CH	Print) RAVE	N B	LVD.	BAL	TIMOR	RE, I	MD 2	1239	
DH	Sta Registr	ar	31. Date filed (Month, Day, Year) MAR 2 4 20	1	rar's Signati		of i								

Physic		1 - For Amend Item 24a per Registrar  1. Decedent's Name (First, Middle, La.  Jennie			Hoskins		2. Date of Deat Month		Year	3. Time of Dea
/Medi Examir		4a. Facility Name (If not institution, give				or Location of Dea		4c. County		10:35
LAGIIIII	101	Manor Care - Tov	son		Tows				timor	e
uneral		Social Security Number     6. S	ex 7. Age (In yrs. □ M 2\notin F		If Under 1 Year Months Days		. (Month, Day,	Year)	9. Birthpli	ace (State or Fo
irector		215-05-8979 Usual Residence of Decedent	88	Yrs.			Dec 12,	1915		yland
A W		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10	d. Inside City I
	ţċ	Maryland Baltin	nore	To	wson					1 🗌 Yes 2
in real many space in years and the manual or lieums 23a or 28a-f show other traumatic event. The Medical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Count	ry?
1238	ië	509 E. Joppa Road			21286			US		
ltems Der n	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race Black	- America k, White, e	in Indian, itc.
, i	by F	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify:	Whi	to
atura cal E	ted	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occur	pation		6b. Kind of Bu		
Med "	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo d)	rking			•
T. T.	် ၁	10	n/a		Homemakeı	1			Home	
even	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, N	laiden Sumame	9)	
is marked other than aumatic event, the Mi	P	James 19a. Informant's Name/Relationship (	Gron		Add (Ct		ementyna			eomski
7 Isr		Robert W. Hoskin		1			ural Route Number,			- 1
tem 27 other tr		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		rrettsvil	Oc. Location - 0	210 City or Tow	
		1 M Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specification)	Hemovai from State		natory or other pla	3/1	8/04			
£ 7 .		21. Si nature of Funeral Service Lice	Dul	22	alley Me.  Name and Addre	ss of Facility		limoniu		
any ir		Bryan weletar	Llery	) ¦	emmon Fur O W. Pado	neral Hom onia Road	ne of Dula l, Timoniu	aney Val	lley 2109	Inc.
edical aminer parial-transit	icai Examiner	resulting in dealth)  Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq  Due to (or as a conseq  C.  Due to (or as a conseq	uence of):	40					
ied by the attending physi detached for use as the l	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3	Ectopic pregnancy Other (specify)	0.00		Mon		ay Yea
slgn d be	ed by	Part II. Other significant conditions of	ic received	Pte	rlure	en in Part I.		acco use contril	oute to the 3 🗀 Probal	
as been 2 shoul	Completed	- WA	t				24a. Was an autopsy			sy findings ava oletion of caus
page 2	Son						perform 1 ☐ Yes 2	ed? de	ath? ⊒Yes 2	
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hamital.			-	ath (Check only one	)		
this al di	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of	77	4 Hoursing F	lome 5 Resider			
After	tion	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	yat k? Yes 2 □ No	28d. Describe hov	r injury occurre	a	
To the Funeral Director: A completely filled in by the fu	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined		ome, farm, str y)			28f. Location (Stre City or Town,	et and Number State)	r or Rural I	Route Number,
nera / fille	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my kno liner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	, and due to the cau irred at the time, dat	ise(s) and man e and place, ar	ner as stat nd due to ti	ed. ne cause(s)
ne Fu	Ž	29b. Signature and title of certifier			29c. Licens			d. Date signed	-	y, Year)
To the Fu completely	_	. //					,	17/1 . 1	1 1	
To the Fu completely		· 5	Rus			61cen		3/14/	04	

O. Box 68760,	
Records, P.O.	
Division of Vital	

			For State Registrar	State of Maryland /	Department o Certificate of		ental Hygier Reg. 1		09233
	Physicia /Medic		1. Decedent's Name (First, Middle, L LATTAIN E		SON		2. Date of Death Month E	15, 2004	3. Time of Death
	Examin Funeral Director	er	5. Social Security Number 6. 15-22-5015	ive street and number)  AM HOOPHOIL  Sex   7. Age (In yrs. last.)	birthday) If Under 1 Y	m, or Location of Death  WV C ear If Under 24 Hrs. ays Hours Min.		4c. County of Death	nplace (State or Foreign unity)
	with the Maryland a or 28e-f show Lee rutified at	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location	<b>-0</b> )	1		10d. Inside City Limits 1 Yes 2 □ No
1	In with the 23s or 28e	ai Director	10e. Street and Number	H Street	10f. Zip Cod	218		Citizen of What Co	untry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Department of Health and Mental Hygiens in Intropremit it flem 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Madical Examinatinatinat be rigitized at once.	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify (	of Hispanic Origin? (Spec Cuban, Mexican, Puerto R Yo Specity:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify:	
_	i within 72 ho liene. r than "natur Ine Madical	Completed	15. Decedent's (Specify only highest of Elementary Schafdar) (0-12)		Ga. Decedent's Usual Oc (Give kind of work de (Ha) DO NOT use re	one during most of working	7 F	Kind of Business/I	ndustry
Maryland 2	permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiene. Important: If item 27 is marked other than any injury or other treumatic event, ILLAM, ODGE.	To Be C	17. Father's Name (First, Middle, Later Land KNOW	IN		18. Mother's Name (	Know	Ú	
e, Mar	l and 2 sh fealth and im 27 Is m her treum	٢	19a. Informant's Name/Relationship  Roland E-Joh  20a. Method of Disposition	NSON (SON) 1	9b. Mailing Address (Sta	blewood  Da	ld, Ba	y or Town, State, Z	21239
Baltimore,	t. Pages I tment of H rtant: If ite njury or ot		Burial 2 Cremation 3	□Removal from State Bud	tery, crematory or other	Cenery 3/2	2/04 [	Balk.	MD.
Bal	permii Depar Impor any ir		U	e Grane	Vange 4905	YOLL P	l, Belo	6.MD 2	1212
F	Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused the death. D ty one cause on each line.	patic Dic		respifatory arrest,		Approximate Interval Between Onset and Death
E	/Medical Examiner	<b>3</b> -1	resulting in death)  Sequentially list conditions,	b. He patition but to (or as a consequence but to (or as a	(C)		***		
R.	cate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	,				
		dicai		d					
O. Box	w requires that the death certify been signed by the attending should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/lths? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea  4 Pregnant at time of death 9 Unknown				23d. Date of deline Month	very Day Year
rds, P.O	quires that t in signed by uld be detai		Part II. Other significant conditions	s contributing to death but not resulting	g in the underlying cause	e given in Part I.	1		the cause of death?
l Rec	The law ate has b page 2 sl	Completed					24a. Was an autopsy performed?	prior to c	opsy findings available ompletion of cause of 2 No
Vita	Physicien: this certificatal director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Impatient 2 ER/	Outpatient 3 DOA	26. Place of Death of Other: 4 ☐ Nursing Home	(Check only one)  e 5  Residence	6 ☐ Other (Spec	ify)
sion of	Attending Phr r death. ector: After thi by the funeral	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury 28b (Month, Day Year)			d. Describe how in		
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certifle	3 Suicide 6 Could not determine	building, etc. (Specify)			3f. Location (Street City or Town, Sta	ate)	
:	he Hosp n 24 hou he Fune pletely fil	Medical	29a. Certifier 1 ☐ Certifying 1 ☐ Certifying 2 ☐ Medical Ex	Physician: To the best of my knowled aminer: On the basis of examination and manner stated.	and/or investigation, in r	my opinion, death occurred	d at the time, date a	and place, and due	to the cause(s)
	Yot With Tot	Σ	29b. Signature and title of certifier	, MO	29c. Li	cense number	29d. [	Date signed (Month	Bay, Year)
<del></del>	6		A A A A A A A A A A A A A A A A A A A	o completed cause of death (Item 23:	a) (Type, Print)	BIVE BA	Himon	MD	21230
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 4 200	32. Registrar's Signature	Asa do	ense number  5 000  1 BAVA, BA		- (1-,45 6	

CALV]	IN J. JC	YC:	For Amend Item #10e per in G834 Department of Health and Me 1- Registrar Certificate of Death	ental Hygie	en <b>2</b> 004	09234
	Physic /Medi			2. Date of Death	Day2, 2004	3. Time of Death 0546 A M
	Exami		4a. Facility Name (If not institution, give street and number)  6810 REISTERSTOWN ROAD ROOM #315  4b. City, Town, or Locetion of Death BALTIMORE CITY		4c. County of Death	
	Funeral Director		5. Social Security Number  6. Sex 12/4-88-86/8  12/4-88-86	8. Date of Birth Month, Day, Y	9. Birthp 1962	ace (State or Foreign
	with the Maryland a or 28a-f show be notified at	Director	10a. State 10b. County 10c. City, Town or Location Baltinore		10	d. Inside City Limits
	eath with the	erai Dire	10e. Street and Number 2111 Popular Grove Street  2/11 Popular Grove Street  2/2/10		Citizen of What Coun	
036	urs after de al', or Itam Exerciment	by Funeral	11. Marital Status  1  Never Married 2  Married  3  Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2	ify Yes or No- ican, etc.)	14. Race · America Black, White, e	
Baltimore. Marvland 21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or ftema 23a or 28a-1 show the Maryland Exertine motified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	7	FURNITUR	
and 2	s 1 and 2 should be filed within female and 2 should be filed within female Hygiene. Item 27 is marked other than other traumatic event, the Man	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19. Depart	First, Middle, Ma		
. Mary	and 2 should leath and Mening 27 is markener traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural F  Velte M. Sayce (wife)  2111 Poplar Gove	Route Number, C		Code) 21216
timore	permit. Pages 1 a Department of Hez Important: If item any injury or othe		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  1  Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetary, crematory or other place)  3  Z 3	104 K	Location · City or Tov	m, State
Ba	permit. Departr Imports any inji		21. Signatury of Funeral Service Licensee  22. Name and Address of Facility Green and Address of	Ave. T		Sea. 2. Zizza
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (qr as a copsequence of):	espiratory arrest,		Approximate nterval Between Onset and Death
	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
8760,	sate be executed hysician and the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):			
P.O. Box 68	ath certific ttending p or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   9   Unknown   1   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   9   Unknown   1   Unknown   1   Vertical Pregnant at time of death   5   Other (specify)   1   Vertical Pregnant	23d. Date of deliven	ay Year	
	w requires that the debeen signed by the a should be detached to	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	cause of death?
✓ Vital Records,	The law ate has b page 2 sl	Completed		24a. Was an autopsy performed	l?   deaula?	y findings available letion of cause of
Division of Vite	Phys this al di	Certification; To Be	27. Manner of Death  1   Natural   5   Pending   28a. Date of Injury C. 38b. Time of Injury at Work?  2   Accident investigation   3   Suicide   6   Could not be	5 Residence  Describe how in	ct henge	d self
Div	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time date and place and	City of Jown, S	18 Cotting to	Agute Number, Round F.
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical	(Check only one)  XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signalure and title of certifier  29c. License number  O.C.M.E	29d. I	and place, and due to the Date signed (Month, Date ARCH 12, 20	v. Year)
	X		39: Name and address of person who completed causer of death (Item 23a) (Type, Print)  The Constant of the Con			
	Sta Registr		31. Date filed (Month, Day, Year)  Registrar's Signature  MAR 2 4 2004	,		

			For Stata Registrar	State of M	larylan	d / Depa	artmei <i>rtifica</i>	nt of He te of L	ealth a Death	and M	ental Hy	giene Reg. No		Ļ	09235	
			Decedent's Name (First, Middle, Las	t)							2. Date of De				3. Time of Death	
	Physici		Richard				ahi	1.50 N			Month March	/ S	700	ar 4	4,30 AM	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number	·)		-///	Town, or	Location	of Death		40	. County of [	Death		
	LAdimi	C:	Good Samuntan	Hospita	/		Bal	tim	17.	Mary	land		N/A			
	Funeral		5. Social Security Number 6. S	9x / 7. A	ge (In yrs.	last birthday)		r 1 Year	If Under		8. Date of Bi	rth Year	9.	Birthp	lace (State or Foreign	
	Director		216-34-4395	<b>⊠</b> M 2□F	6	7 Yrs.	Months	Days	Hours	Min.	SEPT 3				LAND	
	0		Usual Residence of Decedent													
	yian how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	Od. Inside City Limits	
	a Para	cto	MARYLAND N/A		P	BALTIMO	RE								1X Yes 2 □ No	
4	or 28	Director	10e. Street and Number				10f. Z	p Code				10g. Ci	tizen of Wha	t Coun	try?	
	23e	al	2606 SOUTHERN A	VENUE				21214					.S.A.	١.		
	Bas dea	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	.S. 13.	Was Dece	edent of His	spanic Ori	igin? (Spe 1, Puerto I	cify Yes or No Rican, etc.)	0-	14. Race - A			
က္ဆ	or it	F	1 Never Married 2 Married	1 ∐ Yes 2 Ž lf Yes, Give	No	1	1 ☐ Yes		Specify:				Specify: B	T A C	77	
g	within /2 nours affer death with frie maryland ene. Than "neturel", or items 23e or 28e-f show the Madral Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates	:											
, a	nett	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece (Give	kind of w	ual Occupa ork done d use retired,	ation <i>Juring mos</i>	t of worki	ng		Kind of Busin			
21215-0036	. <b>6</b> 6	μ	Elementary/Secondary (0-12)	College (1-4o	5+)				,			ВО	ARD OF	ED	UCATION	
<b>~</b>	Hygie Other t		11th grade   17. Father's Name (First, Middle, Last)			GROUI	NDSMA	·IN	18 Moths	er's Name	(First, Middle	Maide	n Sumame)			
Juc :	ad of	Be		<b>.</b>							MAE AMO		,			
<u> </u>	should to	မ	HENRY C JOHNSON			405 14-11		- (Chront o			I Route Numb		or Tourn Sto	to Zin	Codol	
Maryland	raum		19a. Informant's Name/Relationship (			1	-									
6	ges 1 and 2 should be filed within 72 hours after death with the marylan it of Health and Mental Hygiene.  If of Health and Mental Hygiene is to Heams 23e or 28e-f show the marked other than "neturel", or items 21s marked other than "neturel", or items 23e or 28e-f show or other traumatic event, the Modeal Examinat must be notified at		Rosie V. Johnson/ 20a. Method of Disposition	Wife	20h. F	Place of Dispo	sition (Na	ame of			ltimore		aryıan .ocation - Cit			
0	t of t		1XX Burial 2 Cremation 3	Removal from Stat	1 0	emetery, cre	matory or	other place	θ)							
Ë	tmen tent: tent: jury		`4 □Donation 5 □Other (Specifi		HOI	LLY HI		171		03-23	3-04	MI	DDLE R	IVE	R, MARYLAN	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tra once.		21. Signature of Funeral Service Lice	500	1221	I	AILLI	and Addres AM C W NOI	BROW	Ń COI	MMUNIT	Y FU	NERAL	HOM	E P.A.	
			23a. Part1. Ent 1 the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the deat							arrest,		T	Approximate Interval Between Onset and Death	
	death certificate be executed  a strength of the purial-transit  death certificate be executed  a strength of the purial-transit  and for use as the burial-transit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coron Due to (or a c. Due to (or a d.	s a conseq	Ap- fe uence of):	ry	Disc	*SO							
89	ndiffica ng ph	Med	IF FEMALE:													
P.O. Box	that the death certific ed by the attending pl detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1□Live birth 4□Pregnant 9□Unknown	2 ∰ Feta at time of d	ıl death 3[	⊒Ectopic ⊒ Other (s	pregnancy specify)					23d. Date o Month	f delive	ny Day Year	
			Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	ınderlying	cause give	en in Part I		23e. Did	tobacco	use contribu	te to th	e cause of death?	
sp.	uires sign ld be	d by	Diapetes ine	llites							1 🗆	Yes 2	2 □ No 3 (	Prob	ably 4 Unknown	
Vital Records,	w requir	Completed	Hypertension	20							24a. Wa:	s an	24b. Wer	e auto	psy findings available	
Re	0 2 0	E D	11/1/1/201010	<i>e</i> 1								ormed?	dea	th?	npletion of cause of	
a			11/1/1/10/01	119							1 Yes	2 1 N	0 1 🗆	Yes	2[AN6	
₹ :	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		155/0		Othe	ar.		(Check only		2 CO15	· · · · · ·		
ot	Phys this ral di	은	1 Yes 2 No 27. Manner of Death	1 1 Inpa		ER/Outpatie		28c. Injury	4   14		ne 5 Res 28d. Describe			<i>эрвсп</i>	()	
	ling After funei	lo	1 ☑Natural 5 ☐ Pending	(Month, L	ay Year)	Injury	м	Work	<br Yes 2 □			,	,			
Division of	To the Naspital or Attending Physician: within 24 hours after deads. To the Funeral Director: After this certific completely filed in by the funeral director.	Certification;	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide	e 28e. Place of I	njury - At h etc. (Specia		reet, facto				28f. Location City or To	(Street a own, Stat	nd Number ( 'e)	or Rura	l Route Number,	
_^	To the Hespital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	ysician: To the be niner: On the basis and manner	of examina	owledge, dea ation and/or in	th occurre nvestigation	d at the tim	ne, date ar pinion, dea	nd place, a	and due to the ed at the time	e cause(s	s) and manne nd place, and	er as st	ated. the cause(s)	
	Vithir To th	Me	29b. Signature and title of certifier	10 /	10		2	9c. License	number			29d. Da	ate signed (A	Aonth,	Day, Year)	
	1		Michael	Il like	Kun	MD.		RES	00	0		Ma	ich,	18	, 2004	
1			30. Name and address of person who	1/5cm	MD.	56	Print)	loch	Ra	ven/	Bluf	13.	e/tim	りて	MD, 21239	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	100 32. 10 gi:	strar's Signa	ature A	Carl									

		-	For State Registrar	State o	f Maryland	/ Depa	artment o	of Hea of De	alth ar eath	nd Me		ene20	04	09236
	Physicia	an	1. Decedent's Name (First, Middle, L							1	Date of Death	Day	Year	3. Time of Death 8:05 PM
	/Medic Examin	al	SHIRLEY  4a. Facility Name (If not institution, g	MAE ive street and nu	JENNING	S	4b. City, Tov	wn, or Lo	cation of	Death	· Iou Cr	4c. County	2 1 "	
	LXamin		Franklin Sq	vare	Hospit	al	R 0 S	sea	Under 24	e a Hrs. I o	Data of Bids	Ba		nore
	Funeral Director		5. Social Security Number 6. 214-66-5627	Sex 1 □ M 2 🖾 F	7. Age (In yrs. Ia 46				Hours	Min.	Date of Birth (Month, Dey, IARCH 2	Year) 0 1957	Cour	place (Stete or Foreign ntry) RGINIA
>	D.		Usual Residence of Decedent  10a, State 10b, County		10c. City	Town or Lo	cation						1	0d. Inside City Limits
2	Maryla f sho	tor		rimore c		SEX								1 ☐ Yes 2 🖾 No
Shirley	or 28a	Funeral Director	10e. Street and Number	TITOTED C			10f. Zip Co	ode			16	g. Citizen of V	What Cour	ntry?
S	after death with or Items 23s or in instrinus! Death	erail	1408 HADWICK DI	12. Was Dec	edent Ever in U.S	. 13.	Was Decedent	1221 t of Hispa	anic Origi	in? (Speci	fy Yes or No-		e - Americ	can Indian,
5 9	n 72 hours after death with the Marylar *natural*, or Items 23a or 28a-f show edical Examinat must be notified at	/ Fun	1 Never Married 2 Married	If Yes, G	ve	i	if Yes, specify 1 ☐ Yes 2 ☐		Mexican, Specity:	Puerto Ri	can, etc.)		ck, White, V: BLA	
NN 1NG 21215-003	hours in Exa	ed by	3X Widowed 4 □ Divorced  15. Decedent's	Year or D	ates:	16a. Dece	dent's Usual O	occupation	n			16b. Kind of Bu		
215	within 72 ene. than nai	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (		(Give life.	kind of work a DO NOT use r	done durii retired)	ng most o	of working	'			
	e filed within al Hygiene. I other than vent, Iza Ne		10th grade	st)		DIS	ABLED	18	3. Mother	's Name (	First, Middle, A	N/A Maiden Suman	ne)	
Je Maryland	2 should be f and Mental I Is marked of aumatic eve	To Be	JAMES MORTON						L	UCY N	ORTON			
Aary	2 should and Men is marke reumetic		19a. Informant's Name/Relationship								Route Number,			
	s t and 2 should be filed within thealth and Mental Hygiene. Item 27 is marked other than other traumatic event, the Mental than the Mental th		Tameeta Jenning 20a. Method of Disposition											
Baltimore,	permit. Pages t and Department of Health Important: If Item 2: eny injury or other to		4 ☐ Donation 5 ☐ Other (Spe		State	-	CEMETE		0	3-22-	-04 L	ANDSDOV	WE.	MARYLAND
3alti	permit. Departr Imports eny inje		21. Signature of Fin eral yadas a log	here	/	2: W								FORD, P.A.
	40200		23a. Pert. Enter the disease, or co shock, or heart failure. List on	mplications that	caused the death.	Do not en							1, MA	RYLAND 21001 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Co	ngest	Ive	Hear	+ F	Fai	lure	2		2	Onset and Death  WELKS
	/Medical Examiner		resulting in death)  Due to (or and consequence of):											
	19 8	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of): their Uniform defiate nate of										
	executed an and rial-transit	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	C	(or as a conseque	ance of):								
760,	ate be ex hysician the burial	icai E		d	(or as a consequi	silco or).								
89	rtificate ng phys	ed	IF FEMALE.	- U.										
Вох	Attending Physician: The law requires that the death certificate be executed rideath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1☐Live	utcome of pregnant birth 2 Fetal a mant at time of de-	death 3	☐Ectopic pregr ☐ Other <i>(speci</i>						ite of delive onth	ery Day Year
P.O.	t the de by tha a	hysic	1 Yes 2 No 9 Unknown	9 Unki		a(ii )[				- "				
o.	res that igned be be det	þ	Part II. Dther significant conditions	contributing to	death but not result	ting in the u	nderlying caus	se given i	in Part 1.			~	tribute to tl	he cause of death?
ord	w requir been si should l	Completed	ACUTE REST	DIVAT	IN FO	lilv	ro				1 ☐ Ye			
Rec	The law ate has page 2:	omp	Thrombo	CV+0	Denic	1					autops perform	y ned?	prior to co death? 1  Yes	opsy findings available impletion of cause of
/ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	7,0	PCITIC				6. Place	of Death	Check only on			
of V	Physic rthis or ral dire	- L	1 Tyes 2 No 27. Manner of Death			R/Outpatie 28b. Time o		Other: . Injury at Work?			e 5 Reside			(y)
ion	ttending I death. stor: After	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	tion	nth, Day Year)	Injury	М		s 2□N	lo				
Division of Vital Records,	i i i i	Certification;	3 Suicide 6 Could no 4 Homicide determin	ad 280. Plac	e of Injury - At hor ding, etc. (Specify)	ne, farm, st	reet, factory, o	office	-	28	If. Location (St City or Town	reet and Numb n, State)	er or Rura	al Route Number,
_	spita ours neral filled	Medical Co		eminer: On the	ne best of my know basis of examinati									
	To the Howithin 24th To the Fluctuation	Me	29b. Signature and title of certifier	$\mathscr{J}$				icense n		- 01		9d. Date signe		- ·
	1		1 4/11/1	DIM	>					296		3-17		
1	4		Dr. Jacob Bl	no completed cal	use of death (Item	23a) (Type	Print) Prank	din	Sai	vare	Drive	Balt	imor	e, HD21237
	St	ate	31. Date filed (Month, Day, Year)	AR 2 4 71	Registrar's Signat	ure	IS A	A STATE OF	V			/		,

			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artmen rtificat	t of He e of D	alth and eath	Mental Hy	giene Reg. No.	2001	09237
		202	Decedent's Name (First, Middle, Last)						2. Date of De	eath		3. Time of Death
	Physici /Medic		MANGSSEH JO	THNSON SE.					March	Day 2/	2004	1 10:35 A. M.
	Examin		4a. Facility Name (If not institution, give s			4b. City,	Town, or L	ocation of Deat	h	4c.	County of Dea	th
			GENESIS GlOER CARS	NURSING Hom	2 6		4time.				NA	
ſ	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under Months		f Under 24 Hrs Hours Min.		ay, Year)	C	thplace (State or Foreign ountry)
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	f aho	ō	MD N/a		1 timon							1. PŶes 2 □ No
	28a	Director	10e. Street and Number	1347	ITIMOR	2 10f. Zip	Code			10g. Citi	zen of What Co	ountry?
	N will	O	2219 CECIL AVENU	9		21	218			U:	5.A.	
	death	Funeral		2. Was Decedent Ever in U Armed Forces?	.S. 13. \			anic Origin? (S	ipecify Yes or Ni to Rican, etc.)	0-	14. Race - Ame	
15-0036	be filed within 72 hours after death with the Maryland ital Hygiene. did Hygiene. did other than "natural", or items 23a or 28a-f ahow other than "natural", or items 23a or 28a-f ahow event, the Medical Examiner must be notified at	by	1 ☐ Never Mamed 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:			2 2 No	_	to ricall, etc.)		Black, Whit	te, etc. GCL
2	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	dent's Usua	al Occupation	on ring most of wo	deina	16b. Ki	nd of Business	
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2	filed wi Hygien thar th	S	8	0	CRAIN	_OPE			· · · · · · · · · · · · · · · · · · ·	1	hlehem	Steel
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Ž	should be filed within and Mental Hygiene is marked othar than umatic event, the Mental colors is the Mental colors in the Mental colors in the Mental colors is the Mental colors in the Mental colors in the Mental colors is the Mental colors in the Mental colors in the Mental colors is the Mental colors in the Mental color	으	William Johnson  19a. Informant's Name/Relationship (Type	a Printl	10b Mailie	a Addross		Nancy	Iral Route Numb	ar Citro	Town State	Zin Code l
Maryland	d 2 sl th an t7 is r traur		Manasseh Johnson						ME MD 3			ZIP Code)
	Heal Heal tem 2		20a. Method of Disposition		Place of Dispo cemetery, cren	sition (Nar	ne of	DOCTION	Date		cation - City or	Town, State
Baltimore,	Pages nent of int: If it iry or o		Burial 2 Cremation 3 Re						Mal	R	1/	10
	ortar injur		21. Signature of Funeral Service License	1-ALL	22	. Name ar	nd Adress	of Facility 15	EHS FUN	enal	Home	MU
ä	permit. Pages 1 and 2 should be Department of Health and Monta Important: If Item 27 is marked any injury or other traumatic a <u>once</u> .		Saturia Br	th					St BA,			
	(V = 0)		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat								Approximate Interval Between
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687		edicai	d	,								
Box	death certific attending p	N/W	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna						2	3d. Date of de	livery
m.	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pr Other (sp					Month	Day Year
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ord	w require been si should t		grill stage Review	Vicinie 9	<u>UNIVI</u>	M,	LIPA	<u>(1) ·                                    </u>	1 🗆	Yes 2	□No 3□Pr	robably 4 Unknown
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	To the Hospital or Attending Physician: within 24 hours after dearh. To the Funaral Diractor: After this certifica completely filled in by the funeral director,	ledical (	29a. Certifying Phys (Check only one)  Certifying Phys  Certifying Phys	ician: To the best of my known to the basis of examina and manner stated.	wledge, death	occurred estigation	at the time, , in my opin	date and place ion, death occu	, and due to the irred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
	omple	Mec	29b. Signature and title of certifier			290	. License n	umber		29d. Date	signed (Mont	h, Day, Year)
}	->-0		Martha Lounne	india ino		10	5451	1		3/23	104	
	Y		30. Name and address of person who cor	mpleted cause of death (Item	n 23a) (Type, i	Print)	17316	)		1	107	
	1		MARTHA RAYMUNDO MI	D 5001 4000 NO			celhm	no UD.	21237			
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Signa								
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2:22P March 2004 James A. Jones, Sr. l 6 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Ritchie Hospice Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) March 2, 1917 Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** 1**X** M 2 ☐ F 87 Maryland 213-01-2169 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County in than "natural", or items 23e or 28e-f show the Modical Examinar must be notified at 1 ☐ Yes 2 No Catonsville Maryland Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21228 515 Bloomingdale Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give filled within 72 hours after t Never Married 2 Married 1 ☐ Yes 2K No Maryland 21215-0036 Specify: White þ 3 Nidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Truck Driver 6 permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other trans any injury or other traumatic event, Ita once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James C. Jones, Jr. Marion Reese 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 515 Bloomingdale Avenue Catonsville, MD 21228 James A. Jones, Jr. (Son) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3-19-2004 Baltimore, Maryland Loudon Park Cemetery ! 4 □ Donation 5 □ Other (Specify) <sup>22. Name and</sup> Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave Catonsville, Maryland 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Obst Chronic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): attending physician 68760 Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 □ No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 Yes 200 No 1 ☐ Yes 2 No certificate Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3 DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient ō 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death Certification: After 5 Pending investigation Division 1 Natural 1 ☐ Yes 2 ☐ No death. after death 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 22907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 NI EUTAW ST SALTIMONE MD 2120 TZHNAN MS ANANDA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 4 2004 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2001 09239 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Kassahun Begashaw 13, March 2004 6:50P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F N/A Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits of other then "naturel", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2K No Director Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8750 Georgia Avenue, #520A 20910 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked N/A item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental Kassahun Begashaw Wubsira Yifru 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Begashaw (Father) 8750 Georgia Avenue, #520A, Silver Spring, Md. 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Importent: if it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory March 22,2004 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Beltsville, MD 22. Name and Address of Facility
Rapp Funeral And Cremation Services
933 Gist Avenue Silver Spring, MD 20910 21. Signature of Funeral Service Licensee 700de/1401261 Erin (1.0 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, Due to (or as a consequence of) day leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has 1 Yes 2 No 1 ☐ Yes 2 13t No. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 🗓 No 2 ER/Outpatient 3 DOA I hours after death. unerel Director: After this sly filled in by the funeral d 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funerel C 29a. Certifier 1💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day Year) 29b. Signature and title of certifier 7613 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Roy Brooks., MD 1500 forest Glen Rd Silver Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 21, 2004 8:00P Arline Loretta Knight March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Forestville 1855 Addison Road South If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 212 F 244-38-8485 May 21, 1916 Director 87 Massachusetts Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in then "neturel", or Items 23a or 28a-f show the Medical Examinatives to inclined at 1 ☐ Yes 2 ☑ No Maryland Prince George Forestville Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1855 Addison Road South 20747 United States Funerai within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: African-1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Completed by 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cab Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Carrie Burrell G.C. Harman ၉ of Health and Nitem 27 Is man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Knight, Sr/Spouse 1855 Addison Road South; Forestville, MD 20747 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 03/26/2004 Suitland, MD 21. Signature of Funeral Service Licensee Simple Tribute Funeral and Cremation Center My 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, Tany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed Arteriosclerosis physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as the the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the all ☐Yes 2X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Hypertensive Heart Disease 1 ☐ Yes 2 X No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus 24a. Was an autopsy performed? (es 2\(\tilde{\Delta}\) No has page 2 1 ☐ Yes 2 ☐ No certificate 1 TYes Renal Insufficiency 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 NResidence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Injury Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. hours after death unerel Director: / 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 4 - Homicide filled within 24 hours a
To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25618 March 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1160 Varnum Street NE; Washington, DC 20017 Louis Marshall, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 4 2004

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene 2 1 1

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARKCH 2 X 2 4 **Physician** 04:30 ANY SUN HO KIM /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution give street and number) **Examiner** 6. Sex 2 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours MAY 20, 1933 JAPAN Director 214-15-2517 70 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.
ent: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other than "natural", or items 21a or 28a-f show ury or other traumatic avent, the Marical Exertical institute notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State XXYes 2 □ No Directo BALTIMORE MARYLAND N/A 10g. Citizen of What Country? UNITED STATES 10e. Street and Number 10f. Zip Code 1027 CATHEDRAL STREET, APT. 12L 21201 OF AMERICA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2\X\No If Yes, Give 1 Never Married XX Married 1 ☐ Yes ZXNo Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Year or Dates: ASIAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHOTOGRAPHER KOREAN NEWSPAPER 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be AH JEE KIM 7 BOK JOONG KIM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2429 CLOVER FIELD CIRCLE; HERNDON, VIRGINIA 20171 JAE S. KIM (SON) 20b. Place of Disposition (Name of cometery, crematory or other place)
DULANEY VALLEY
MEMORIAL GARDENS Date 20a. Method of Disposition 20c. Location - City or Town, State MARCH 25, 2004 XXBurial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. GARDENS 2004 TIMONIUM, MARYLAND 22. Name and Address of Facility LOUDON PARK FUNERAL HOME 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Se vice Lice see 3620 WILKENS AVENUE BALTIMORE, MARYLAND Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ISCHEMIC CARDIOMYOPATHY **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last anding physician and use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death P.0. 9 Unknown as been signed b 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, The law requires 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed: page 2 No certificate 1 ☐ Yes of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 X patient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death
Natural
Control 28b. Time of Injury Date of Injury (Month, Day Year) 28d. Describe how injury occurred To the Hospitel or Attending Division 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deal To the Funerel Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide filled in t 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie 104 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P LIM, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 4 2004

	•	State of Maryland / Department of Health  1- For State State State of Maryland / Department of Health  Certificate of Deat			ene 2004	09242
Physic /Medi		Decedent's Name (First, Middle, Last)  Carl William Kaiser	N	Date of Death Month March 20	Day Year 0, 2004	3. Time of Death  12:25 P
Exami Funeral Director	ner	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location Street and number Appears Appear Appears	ider 24 Hrs. 8.	Date of Birth (Month, Day,	4c. County of Death Harford  Year) 9. Birthy County 1924 New	
G.	Director	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Harford Fallston				1 Od. Inside City Limits 1 ☐ Yes 2 🂢 No
13-UU30 72 hours after death with the Maryland "natural", or Iteme 23a or 28a-f show adjeal Examinat must be motifiled all	Funeral	10e. Street and Number			USA  14. Race - Amen Black, White,  Specify:	can Indian,
112 15-UU30 I within 72 hours after death with iene, rthan "natural", or Iteme 23a or the Wedical Examinar must be	Completed by	3 Widowed 4 Divorced Year or Dates: 1943-45  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  2  Insurance Salesma	most of working	1	Whi 6b. Kind of Business/Ir	
Yeand Into Into Into Into Into Into Into Into	To Be Co	17. Father's Name (First, Middle, Last)	iother's Name <i>(I</i> Helen	Beatı		ost Code)
MOCE, MAI Peges 1 and 2 st nent of Health and int: If item 27 is n iry or other traun		Betty Mae Kaiser - Wife  20a. Method of Disposition 1 \text{\mathbb{G}} Burial 2 \text{\mathbb{C}} cremation 3 \text{\mathbb{B}} Removal from State}  20b. Place of Disposition (Name of cemetery, crematory or other place)	pad, Fal	lston,	Maryland 2	1047 own, State
Baltimore, permit. Peges 1 ar Department of Hea Important: If item any injury or othe		14 Donation 5 Other (Specify) Highview Mem. Garden  21. Signature Fune a Service Lipensee 22. Name and Address of Fa  50 West Broad	acility McC dway Str	Comas Fi Ceet, Be	el Air, MD	, P.A.
ificate be executed	ical Examiner	23a. Part1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	h as cardiac of r	Portai	Jensim	Interval Between Coset and Death
, P.O. BOX 68 that the death certificated by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy 1   1   1   1   1   1   1   1   1   1			23d. Date of deliv Month	ery Day Year
Records law requires has been sign	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	Part I.	1 Ye  24a. Was ar autopsy	24b. Were autoprior to co	bably 4 Unknown  opsy findings available ompletion of cause of
Of Vita Physician: this certifica al director, p	To Be	examiner?  1	28	Check only one	e 1 Yes e) nce 6 ⊡Other (Speci w injury occurred	2) H6 (y)
Division of To the Hospitel or Attending Phy within 24 hours after death. To the Funeral Director: After this completely illied in by the tuneral of	i Certification;	2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		City or Town		
To the Hospitel or within 24 hours after To the Funeral Dir.	Medical	29b. Signature and title of certifier  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.  29c. License numb	, death occurred	d at the time, da		o the cause(s)
Begis	itate strar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	2100	Xbera	deer, no	in land

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ORIGINAL

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Funeral Director		5. Social Security Number 6. Sep 013-14-3203  Usual Residence of Decedent	7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da March	y Year) 9. Bi 2, 1916 Mas	rthplace (State or Foreig Jountry) SSAChuetts
within 72 hours after death with the Maryland ene. than "natural; or items 23s or 28s-f show the Madical Examiner must be notified at	Director	10a. State 10b. County Maryland Montgomer 10e. Street and Number	у	10c. City, Town or Lo Bethesda	10f. Zip Code		1	10g. Citizen of What C	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. The Medical Examinat must be notified at once.	by Funeral Director	6204 Vorlich Lane  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	0	20816 Was Decedent of H If Yes, specify Cuba	dispanic Origin? (Sp an, Mexican, Puerto Specify:		Jnited Stat  14. Race - Am Black, Whi  Specify: WI	encan Indian, ite, etc.
of 2 should be filed within 72 hours aft that and Mental Hygiene. Ith and Mental Hygiene. 27 is marked other than "natural", or traumatic event. Ithe Medical Examples.	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	DO NOT use retired	during most of work	ing	18b. Kind of Business	·
should be file and Mental Hy marked oth matic event.	e e	17. Father's Name (First, Middle, Last) William North Davi. 19a. Informant's Name/Relationship (Ty.)		19h Mailir	ng Address (Street	Eva Bel	lle Lar	Maiden Sumame)  dry r, City or Town, State,	Tin Code)
jes 1 and 2 s of Health an If item 27 is or other trau	-	Marjorie Franklin  20a. Method of Disposition  1 Burial 2 XCremation 3 B	n (Daughi	er) 6204	Vorlich	Lane, Beth	nesda, M	D 20816  20c. Location - City or	
permit. Pages 1 ar Department of Hea Importent: If item: any injury or other		4 □ Donation 5 □ Other (Specify)  21. Signature of Figure al Service License		Chesapeal				Beltsville Services ing, MD 2	0910
Physician /Medical Examiner	Examiner	23a. Paft1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Sepsis  Due to (or as a	he death. Do not ent-	er the mode of dyin	ng, such as cardiac d	or respiratory and	eest,	Approximate Interval Between Onset and Death 1 wk.
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w requires that the been signed by the should be detach	ted by Phy	9□Unknown Part II. Other significant conditions con Renal Failure		not resulting in the ur	nderlying cause give	en in Part I.		bacco use contribute to	o the cause of death?
iician: The law requires t certificate has been signe rector, page 2 should be c	e Completed	Dementia  Hypernatremia  25. Was case referred to medical					24a. Was a autops perform	prior to death? 2☑No 1☐Yes	utopsy findings available completion of cause of
Phys this al di	10 B	examiner?	28a. Date of Injury (Month, Day	Year) Injury v - At home, farm, stre	28c. Injury Work M 1 🗆 Y	4 kg Nursing Hor / at ⟨? Yes 2 □ No	ne 5 □ Reside 28d. Describe ha	ence 6 Other (Spectow injury occurred	
	edical	29a. Certifier (Check only one)  1 ☑ Certifying Phys 2 ☐ Medicel Examin  29b. Signature and title of certifier	ician: To the best of er: On the basis of e and manner state	ixamination and/or inv	estigation, in my on	oinion, death occurre	ed at the time, d	ause(s) and manner as ate and place, and due	to the cause(s) h, Dey, Year)
3		30. Name and address of person who cor Raman R. Tuli, M.I			Print)	,			rg, MD 2087

			For	State of Ma	aryland	/ Depa	artment of H	lealth and N	Mental Hy	giene		09244			
		•	1 - State Registrar			Cei	rtificate of	Death	F	Reg. No.	2004				
7 4	Physicia		1. Decedent's Name (First, Middle, La CONSTANCE	st)			LEVI	NSKI	2. Date of Dea Month MARCH	Day	Year 2004	3. Time of Death			
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)	_		4b. City, Town, o	r Location of Death			County of Death				
	LAGITIM	<b>.</b> .	HARBOR HOSPI	TAL CE	NTE	R	BALT:	IMORE		1	ALTIN	PORE			
	Funeral Director		5. Social Security Number 216–88–9842	_	e (In yrs. las 45	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 1 1/20/	1958	9. Birth Court Mary	place (State or Foreign arry) Land			
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	neation				1	Od. Inside City Limits			
	aryla •how	_					ocation					1 ¥ Yes 2 □ No			
	8a-1	Directo	Maryland N/A		balt.	imore	10f. Zip Code			10a Citiz	en of What Cour	atov?			
	with I	ă	10e. Street and Number	Ctroot			21223				ed State	•			
	s 23	Funeral	1157 S. Sargeant	12. Was Decedent	Ever in U.S.	. 13.					4. Race - Americ				
	Item Item	Š	1 Never Married 2 Married	Armed Forces?			_	Hispanic Origin? (Sp an, Mexican, Puerto	o Rican, etc.)		Black, White,	etc.			
336	irs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀 No	Specify:		Specify: White					
5-0036	within 72 hours after death with the Maryland ene. Than "naturel", or items 23a or 28a-f ehow the Medical Examiner must be molified at	ted	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	pation during most of work	kina	16b. Kind of Business/Industry					
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N	filed with Hygiene other than	Completed	10			Barma	id		Tavern						
_	o d a	Be	17. Father's Name (First, Middle, Last						Name (First, Middle, Maiden Sumame)						
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ag Marie	2 2 2 3		19a. Informant's Name/Relationship Patricia M. Rehli		r			reet Balt							
e)	1 and Health em 27 ther tr		20a. Method of Disposition	ng - riothe	20b. Pla	ce of Dispo	osition (Name of		Date		cation - City or To				
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 Burial 2 Cremation 3 C				matory`or other pla rematory		h 22-200	4 Ba	ltimore	, Maryland			
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	the 3		23a. Part1. Enter the disease, or so shock, or heart failure. List only	nolications that cause	d the death.	Do not en	ter the mode of dy	ng, such as cardiac	or respiratory a	rrest,	-,	Approximate Inferval Between			
	Physician		fmmediate Cause (Final	ACUTE	GAC.	TOO T	NTESTIN	AL BLE	EDING			Onset and Death			
	/Medical		disease or condition resulting in death)	Due to (or as		ence of):						<u></u>			
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687	physic	dica		_ d											
9 ×	death certificate e attending phys od for use as the	Physician/Medic	IF FEMALE:	23c. If yes, outcome	of pregnan	су				2	3d. Date of defiv	erv			
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	□Ectopic pregnand □ Other <i>(specify)</i> _	;y			Month	Day Year			
P.O.	0 0 0	ysl	1 □ Yes 2 □ No 9 ☑ Unknown	9⊠ Unknown					· ·						
	res that signed b	by Pł	Part II. Other significant conditions	contributing to death t	but not resul	lting in the t	underlying cause g	ven in Part I.	23e. Did t	obacco us	se contribute to t	the cause of death?			
rds	quires in sign	d be	THRMBOCYTO	PENIA					10	Yes 2[	□No 3□Pro	bably 4 Munknown			
Records,	law requires that the as been signed by th 2 should be detache	Completed	ASPIRATION	PNUEMON	IA I	DUE -	To SEIZ	LURES	24a. Was		24b. Were auto	opsy findings available empletion of cause of			
æ	o − 6	Ho							perfo	rmed? 2 ☑ No	death? 1 ☐ Yes				
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			-			ath (Check only o	one)	1				
<b>)</b>	0 0	2	1 Yes 2 No	Hospital: 1 Inpati	ient 2 🗆 E		III SU DOA	The second secon	lome 5 ☐ Resi			fy)			
n of	De Te	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj. (Month, Da		28b. Time o fnjury	Wo		28d. Describe	how injury	y occurred				
Sio	r Attendi er death. rector: A by the fu	catl	2 Accident investigati 3 Suicide 6 Could not					Yes 2 No	28f Location /	Strant and	d Number or Pur	al Route Number,			
Division	after death. I Director: Afte	Certification:	4 Homicide determine	200. Place of II	ntc. <i>(Specify)</i>	ne, rarm, si	treet, factory, office		City or To			ar noute Number,			
	Hospital 4 hours a Funeral (		29a. Certifier 1 ☐ Certifying F	hysician: To the besi	t of my know	viedge dea	th occurred at the t	ime, date and place	and due to the	cause(s)	and manner as	stated.			
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only 2 Medical Ext	aminer: On the basis and manner s	of examinati	ion and/or ii	nvestigation, in my	opinion, death occu	irred at the time,	date and	place, and due i	to the cause(s)			
	To the within 2 To the comple	Me	29b. Signature and title of certifier	_			29c. Licen	se number			e signed (Month,				
	L > F O		) of oh	0- MD			PI	6286		0	3/20/06	+			
	~		30. Name and address of person wh	o completed cause of	death (Item	23а) (Туре	, Print)		-1	_					
	0		POTHURATU NAGABI	14RU 301	ci sou	HHTC	ANOVER S	TREET B	ALTIMORE	= 1V	10 217	2-5			
K	St Regist	ate	31. Date fifed (Month, Day, Year)	. 4	ar's Signat	ure	books								

			For State Registrar	State of Marylan	id / Depa <i>Cei</i>	artment of F tificate of I	lealth and I Death	Mental Hy	giene Reg. No.	2004	09245
	Physici		1. Decedent's Name (First, Middle, Last)  Lest		Lan	gley		2. Date of De Month March	Day	Year 2004	3. Time of Death 1:15 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give		2011		Location of Deatl		- 1	County of Death	
100 E		2	FREDERICK MEN			FREDE	RICK If Under 24 Hrs.	9 Data of Bir		REDERI	
	Funeral Director		5. Social Security Number 223–26–3964 6. Sex	7. Age (In yrs. 81	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da JULY 23	y, Yeer) 1922	2 KE	nplece (Stete or Foreign untry) NTUCKY
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Mary a-f sho	tor	MD CARRO	LL	MOUNT	AIRY					1 ☐ Yes 2 No
:	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number 13202 PENN SHOP I	2040		10f. Zip Code 2177	'1		10g. Citiz	en of What Co	untry?
	death ms 23	Funerai		12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of H		pecify Yes or No		4. Race - Amer	
	be lied within 72 hours after death with the Marylar Hygiene. d other than "naturel", or frems 23e or 28e-f show event, the Marutcal Exerterne must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 XX If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:	o nicari, etc.)		Black, White Specity: W	HITE
213-0030	2 hou		15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occup	ation	rkina		nd of Business/	
Z	within venture of the Merchant	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired L MINER	i)	g	COA	L COMPA	NY
פ	be filed ital Hygi d other event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar			Sumame)	
Z	2 should be and Menta Is marked surnatic ev	To	GEORGE W. LANGL		19h Mailie	ng Address (Street		MILWEE		Town State 7	in Codel
Š	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		JAMES E. LANGLEY/			D2 PENN S					
	iges 1 and of the control of the con		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ P	20b. F emoval from State PLE	Place of Dispo	esition (Name of matery or other place GARDENS	MARQ	Date H		cation - City or	
	permit. Pages 1 Department of H Importent: If ite any Injury or ot once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>						-	RTINSBU	
ñ	Ded E e	W I	Chaela m	Beaun		ROWN FUNER				5402	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the deat ne cause on each line.	th. Do not ent	er the mode of dyin	ig, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Once and Death
	nysician /Medical		disease or condition resulting in death)	Due to (or as a consec	quence of):						Means
2	Examiner	i e	Sequentially list conditions,	Due to or as a cons	uence of):						V
	etated nd transit	Examin	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s							
300	cate be exaguted physician and the burial-transit	ai Ex	resulting in death) Last	Due to (or as a conseq	quence of):						
		Medicai	IF FEMALE:				-				
X R O	death certifi e attending p id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	aldeath 3	Ectopic pregnancy Other (specify)	,		2	3d. Date of deli Month	very Day Year
	o o o	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
ds, -	The law requires that the ite has been signed by the bage 2 should be detached.	by	Part II. Other significent conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	1			the cause of death?
Vital Records,	s been si	olete			3 11			24a. Was	an		topsy findings available completion of cause of
		Completed						auto perfo 1 ☐ Yes	prmed?	death?	2 No
Z Z	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	lospital:		oth	26. Place of Dea				
ō	Phys ar this aral dir	To To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	IL 3LI DUA	4   Nursing F	lome 5 ☐ Resi 28d. Describe			erfy)
Division	ending F sath. or: After he funer	ation	1	(Month, Day Year)	Injury		Yes 2 □ No				
Ë G	after datter date date date date date date date date	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, sti fy)	eet, factory, office		28f. Location ( City or To			ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certifica completely filled in by the funeral director,	edicai C	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occu	a, and due to the arred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	o the lithin 2 o the I omplet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date	signed (Month	n, Day, Year)
	- s + ŏ		> A11/150			DZ	26516		MA	RCH	15 2004
	10		30 Name in a rest con who co	ompleted cause of death (Iter	m 23a) (Type.	Print) TAN	26516	FI	CED	ME	21262
Ä	Sta	ate	31- Date filed (Month, Day, Year) MAR 2 4 200	320 Registrar's Signa	ature	1 / //	-1 110				01106
19.	Regist		MAR 2.4 AIII	4 1 1 1 1 1 1 1	17 6	- 40 -					

State of Maryland / Department of Health and Mental Hygiene 2 1 1 - For State Registrar Certificate of Death 3. Time of Death
9-50 M 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year March **Physician** 2004 15 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner N gryington 305 AthorAV B-Itimore Future Care If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days **Funeral** Hours 1**⊠**M 2□F 248-38-143 01/18/ Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other fraumatic event, the Medical Event and the rollified at once. 10a. State 1 HYes 2 No BALTIMORE MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number NSA 21229 Lynhurst Street 810 12. Was Decedent Ever in U.S. Armed Forces?
1 New 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: BLACK altimore, Maryland 21215-0036 δ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Post Office Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 2yrs 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martin Annie Roosevelt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore MD 21207 5938 Talbott Street Kimberly A. Martin Daughter Date 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Laurel, National MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICES Wansh SISI BALTIMORE NATIONAL PIKE BALTO. MD 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon metastesis a Carcinoma **Physician** 0 /Medical Due to (or as e consequence of) **Examiner** ementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Exami Therosclerenz Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death 9□ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate has 1 ☐ Yes 2 No or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one Other: Hospital: 4.X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 ₽No Certification: To After this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funerel Director: 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Amatyo H Macon MD 15503 0, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMOREMO 501 DOLPHIN AMATUN NIMATEM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 4 2004

DHMH 17 Rev 1/2001

Registrar

nysician		Decedent's Name (First, Middle, Last)  Irene				Mah	namm	itt		2. Date of De Month	Day.	3 2 Yea	3. Time of Deat
Medical xaminer		a. Facility Name (If not institution, give	street and number)					Location of	of Death	17(14)		unty of De	
Adminier	ı	UniversitySp	ecialtyt	HOSP	ital	Bo	21+1	more			/	VA	
neral	5	. Social Security Number 6. Sec			ast birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. B	irthplace (State or For Country) MD
ector	-	213-34-3205 Usual Residence of Decedent	IM ZØGT	71	Yrs.					03 2	7 32		М́D
eumatic avent, the Medical Examiner must be notified at.  To Be Completed by Funeral Director		10a. State 10b. County			Town or Lo								10d. Inside City Lin
Director	3	MD NA		Da	T C TIN	10f. Zip	Code				10g. Citizen	of Miles I	XXes 2
Ö	2					101. Zip	212	20				.S.A	•
Funerai	-	3933 Rokeby Roa 11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S	6. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)		Race - Ar	nerican Indian,
E.		1 Never Married 2 Married	1 ⊟ Yes 2 X	lo	1	1 ⊡ Yes 5			i, Pueno	rican, etc.)		Black, Wl e <i>cify:</i>	
d by		3 Vidowed 4 □ Divorced	Year or Dates:	1									Black
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E	5	Elementary/Secondary (0-12)	College (1-4or 5	+)		ndry					Nurs	ina	Home
BeC	2	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	First, Middle			
일		Levi Davis						Flor	cenc	e Hol	iday		
		19a. Informant's Name/Relationship (Ty								al Route Numb			
once. To B	3-	Jacqueline Kel	Ly-Daugh		210's ace of Dispo			ir i	- Administration	Bal			
	- [ '	20a. Method of Disposition XXBurial 2 Cremation 3 P	emoval from State	ce	metery, crer	natory or o	ther place						or Town, State
	-	<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Ucens</li> </ul>		Gar						/25/0	4 Owi	ngs	Mills, M
once		21. Signature of Funeral Service Ocens	nel		M	Name and a rch	F	I Wes	št	Balt	imore	МA	21215
		23. Part1. Inter the disease, or complishock, or heart failure. List only	cations that caused	the death.								Hu	Approximate
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ai		disease or condition resulting in death)	Due to (or as			Center		- CRITO()					5.44
er		Sequentially list conditions	)	fly pa	ntm sia	21)							YO WW
iner	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or 1s				11 000	^					
Examiner	Yall	that initiated events resulting in death) Last	Due to (or as	_	here	o me	211   702	9					1048
a E	E L			- 001100q0	01.00 01).								
edical	3		1										
Physician/Me		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			Je					23d.	Date of d	elivery
leted by Physician/Med	2	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant at 9□Unknown			Ectopic pro Other (sp.						Month	Day Year
hy		9 Unknown							_				
\ <u>\</u>	בר בר בר בר בר בר בר בר בר בר בר בר בר ב	Part II. Other significant conditions con	1 .		Iting in the u	nderlying ca	ause give	n in Part I.					to the cause of death
eted		Genifile and Carares	(M) C1113-E	201-6						ļ	Yes 2□N	0 3 🛄	Probably 4 2Unkn
Completed	1		·							24a. Was auto		4b. Were prior to death?	autopsy findings avail completion of cause
		05 141								1 ☐ Yes	2 IVNo	1 🗆 Y	as 2 No
Be e		25. Was case referred to medical examiner?  1  Yes 2 No	lospital: 1 Inpatie	nt 2 🗆 G	ER/Outpatier	4 2 DO	A Othe		77-200	(Check only		0	Al .
2		27. Manner of Death	28a. Date of Injur (Month, Day		28b. Time of		8c. Injury Work	4 🗆 140		me 5 🗌 Resi 28d. Describe			о <del>в</del> спу)
atio	2	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	rear)	Injury	М		? /es 2 🔲 l	No				
ti li		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju-	ury - At hor	me, farm, str	eet, factory	, office			28f. Location ( City or To	Street and Na	umber or i	Rural Route Number,
Se	5		l)			-							
edical Certification:	20	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medicel Exemi	ner: On the basis of	examinati	vledge, deatl ion and/or in	occurred vestigation,	at the tim in my op	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner : ce, and di	as stated. ue to the cause(s)
ed		one)  29b. Signature and title of ceptifier	and manner sta	ited.		290	. License	number			29d Date si	aned (Mo	nth, Day, Year)
-   ≥		No.				1		040	14		3/1		
Σ	- 1												,
completely filled in by the funeral director, page 2  Medical Certification: To Be Comp	-	30. Name and address of person who co	ampleted cause of d	eath (Item	23a) (Tune	Print)							

DHMH 17 Rev 1/2001

MAHHMMITT, IKENE

Oivision of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of	Marylan				ealth a	and M		Reg. N	7	04	09249	1
Physic	ian	Decedent's Name (First, Middle, James	<sub>Last)</sub> Delmas	1	Miller					2. Date of D Month March		<sup>a</sup> 2004	Yeer	3. Time of Death 12:30PM M	
/Medi Exami		4a. Facility Name (If not institution,				4b. City,	Town, or	Location o			-	c. County	of Deeth	112.5011	_
LXaiiii		Washington Adve		_				Park				ntgo			_
Funeral Director		5. Social Security Number 235-66-9334	5. Sex 1 2 M 2 □ F	7. Age (In yrs. 64	last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D Jan. 9	ay, Yeer	40	9. Birthp Cour West		1
		Usual Residence of Decedent								Juli , J	, -,				_
arylan ehow	2	10a. State 10b. County			y, Town or Lo									10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
the M	recto	Maryland Montgo  10e. Street and Number	mery	Ta	akoma l	10f. Zip	Code				10g. C	itizen of V	Vhat Cour	ntry?	_
h with 23a or	ai Di	8208 Roanoke Av	enue,#102			20	912				Uni	ted	State	es	
ite; Intallylating E. I.E. 100000000000000000000000000000000000	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Marrie  3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed For d 1 Tyes If Yes, Give Year or Da	ces? 2 🛂 No		Was Dece If Yes, spe 1  Yes		ispanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	0-	Blac	e - Americ k, White, : Whi		
2 hou		15. Decedent's	Education		16a. Dece	dent's Usu	al Occup	ation	t of worki	na	16b.	Kind of Bu	siness/In	dustry	_
ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-	4or 5+)			se retired	during mos	i or workii	ng .		_	-	County	
filed w Hygier Ither th		12 17. Father's Name (First, Middle, L	ast)		Jani	cor		18. Mothe	er's Name	(First, Middle		blic on Sumam		)01S	
La yiai ta K. I.Z. Should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be	James Kenneth	Miller					Es	ther	01ive	S	outha	a11		
id 2 should the and Men 127 is marke traumatic		19a. Informant's Name/Relationshi  Joanne Drummo	p (Type, Print) (Life :	Partner	19b. Mailin 8208	Roan	oke	and Numbe Aveun	e #1	nl Route Numi 02 ,	ber, City	or Town,	State, Zip	Code)	
s 1 and 20 Health item 27 other tra		20a. Method of Disposition		20b. F	Place of Disponentery, creme	sition (Ne	TI O Of		arch	)ate	20c. l	Location -	City or To	own, State	-
Dearth Pages Department of mportant: If it iny injury or o		1 ☐ Burial 2 ☑ Cremation '4 ☐ Donation 5 ☐ Other (Sp.		Che	sapeak			ry	200	4		tsvil			
permit. Pages 1 Department of F Important: If its any injury or ot		21. Signature of Funeral Service L	Thorder .	Uniz 61	R. 9	Pamer 33 Gi	uner: st A	s of Facilit An venue	d Cr Sil	emation ver Sp	n S r <b>i</b> ng	ervio	es 2091	0	
\$		23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cannot one a	used the deat ach line.	th. Do not ent	er the mod	de of dyin	g, such as	cardiac c	or respiratory	arrest,			Approximate Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CAR	die	oul	non	IRR	4	170	RESI	/			Orisot and Doam	_
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	or as a consec	quence of):			.,							_
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wrequires that the death certifica been signed by the attending phy should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ∏ Feta ant at time of c	aldeath 3	⊒Ectopic p ⊒ Other (s						23d. Dat Mod		ery Day Year	
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law requast been 2 should	ompleted									24a. Wa	s an	24b. V	Vere auto	opsy findings available	9
	Com									per 1 🗆 Yes	formed?		leath?	2 □ No	
Or Vital F Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Hospital:				Oth		of Death	(Check only	опе)				_
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VISION Attending ar death. ector: After by the fune	ation	1 Natural 5 Pending 2 Accident investig		h, Day Year)	Injury	м		k? Yes 2□	No						
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After I completely filled in by the funers	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	289. PIACE	of Injury - At h	ome, farm, st fy)	reet, factor	y, office			28f. Location City or To	(Street a	and Numb te)	er or Rur	al Route Number,	
Hospital or 24 hours afte Funeral Dire	Medical		Physicien: To the exeminer: On the battern and mann	asis of examina											
To the within To the comple	Me	29b. Signature and tille of certifier				29	c. Licens	e number			29d. D	ate signed	(Month,	Dey, Year)	_
		) Ta	na				D le	010	0		m	ARC	Н	7,2004	/
		30. Name and address of person v	nho completed caus	e of death (Ite	m 23a) (Type.	Print)	, ,	-	,			1		20912	•
9	tate	31. Date filed (Month, Day, Year)	MA K. 32. A.	A HO egistrar's Sign	∩ E d,		010	CAR	ROL	Au		IAK	ama	TANK, MI	D
Regis		MAR 2	4 2004	hence	e /	9	Ann.	101	4						

State of Maryland / Department of Health and Mental Hygiene 2004

09250 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Month Physician Erma Montgomery March 18, 2004 6:10 am /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Randolph Hills Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Month, Day Ye.
April 21, 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Year) 1□M XXF 79 1924 Virginia Director 579-22-1505 Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ital Hygiene. Id other than "natural", or items 23a or 28a-f ahov event, the Medical Examiner must be notified at 1 XX es 2 □ No MD Director Montgomery Wheaton 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 4011 Randolph Road 20904 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Š 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be end Mental ! unknown unknown 19a. Informani's Name/Relationship (Type, Print)
Guardian of 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Sherry Davis/Personal Depertment of Health important: If Item 27 is any injury or other tra 401 Hungerford Drive, Rockville, MD Property 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Melhod of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State Baltimore Crematory at LP 3/26/04 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Fur eral Service Licen 1040 Rockville Pike Rockville, MD 20852 23a and Entire the riseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Alzheimer's Dementia years Examiner Due to (or as a consequence of) Examiner Sepsis ng physician end es the bunel-transit Hospital or Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) attending p 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 □ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown s certificete hes been signed Jirector, page 2 should be del 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed ZUN 1 TYas 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ٩ 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) s efter death.
I Director: After this of in by the funerel d this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours eft To the Funeral Di completely filled in 1 Ccertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) \$ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D08944 March 18, 2004 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Martin Shargel, 3720 Farragut Avenue, Kensington, MD 31. Date filed (Month, Pay, Year) MAR 2 4 2004 32 Registrer's Signature State E PLANT Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician 8:57 AM 23 FRANK JOSEPH MILEO 200 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Harres teultheare 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** XXM 2□F Yrs. JULY 26, 1916 MARYLAND **Director** 214-05-3912 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other then "natural", or itams 23s or 28s-1 show other traumatic event, the Modical Examinar rough the modified at XXYes 2 No Director MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES OF AMERICA 604 LUCIA AVENUE 21229 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1XXXves 2 \( \times \) No 1944If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MIXOLOGIST 9th RESTAURANT INDUSTRY permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe eny injury or other traumatic event, <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANTHONY MILEO ROSA NOTO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MARYLAND 21229 MARTHA JANE MILEO (WIFE) 604 LUCIA AVENUE: 20b. Place of Disposition (Name of competery, crematory or other place)
LAKEVIEW
MEMORIAL PARK 20a. Method of Disposition Date 20c. Location - City or Town, State MARCH 27, 2004 XXBurial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) SYKESVILLE, MARYLAND FUNERAL HOME 22. Name and Address of Facility LOUDON PARK FUNER 3620 WILKENS AVENUE BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee. O. Chmach Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** days Decompensated /Medical Due to (or as a consequence of): **Examiner** Cardianyo

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s performed? 1 ☐ Yes 2 No Vital Hospital or Attanding Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ivision 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Fune completely ( (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SANJAY VINJAMARAM, MD 03/23/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 caten Ave Baltimore, MD 21229 31. Date filed (Month, Day, Year) MAK 2 4 ZUU4 32, Registrar's Signature State paren de forte Registrar

DHMR 17 Rev 1/2001

Frank

ORIGINAL

		•	For State Registrar	State of Maryland / D	)epa		lealth and N	Mental Hygic	_	09253
			1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	Physici: /Medic		Violet	May	M	oberly		March 20	), Day 2004 Year	9:35pm м
	Examin		4a. Fecility Name (If not institution, give			•	r Location of Death		4c. County of Death	
			5955 Quinn Orcha				erick		Freder	
	Funeral Director		5. Social Security Number  219-03-0999  Usual Residence of Decedent	7 to 307 c	rhday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Y) Mat 14,	1919 Ohi	nplace (State or Foreign untry) O
000	show a show	ı	10a. State 10b. County Maryland Freder	10c. City, Yowr		cation rick				10d. Inside City Limits 1 ☐ Yes 2 ▼No
di M	or 28a-f	Director	10e. Street and Number			10f. Zip Code	04707	10g	g. Citizen of What Co	-
4	238	rai	5955 Quinn Orcha		1.5.		21704	7. W No.	U.S	
5-0036	permit. Pages 1 and 2 should be lifed within 72 frouts after deets with the waayaat Department of Health and Mental Hygiene. Departments if them 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic evant, the Madical Examinating that be notified at once.	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of his fixes, specify Cub	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
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121	the Med	ompie	(Specify only highest grad	College (1.4or 5+)		emaker	during most of work d)	ling	Own Home	
9 2	Hygin ant,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	uiden Sumame)	
a a	Mental   Mental   arked o	To B	Edward	Greystoke			Marga	ret	Riedel	
Mary	h and M 7 Is mai		19a. Informant's Name/Relationship (7) Mrs. Jeanne Llyo						City or Town, State, Zick, Maryl	_
e,	Health em 27	li	20a. Method of Disposition	20b. Place of	Dispo	sition (Name of		Carrier and Carrie	c. Location - City or	
mor	ent of ent of nt: If It ry or o		1 ☐ Burial 2 【Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			natory or other pla g Cremat		, 2004 S	Smithsburg	, Maryland
Baltimore,	permit. Page Department important: If any injury or once.		21. Signature of Funeral Service Licens		22	. Name and Addre Keeney	& Basford	P.A. Fun	eral Home	
	nysician	NT N	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the death. Do not cause on each line.				, Frederi or respiratory arres	ck, Maryl	Approximate Interval Between Onset and Death  Years
	/Medical Examiner	Iner	resulting in death)  Sequentially list conditions, Tay learny to the cause. Enter Underlying cause, (Disease or injury)	b. Asthma Due to (or as a consequence of the conseq	of):					
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O. Box	The law requires that the death certificate tie has been signed by the attending phys age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnand Other (specify)	у		23d. Date of deli Month	very Day Year
ds, P.O	ries that signed by I be deta	b	Part II. Other significant conditions co	ontributing to death but not resulting in	n the u	nderlying cause gi	ven in Part I.		cco use contribute to	the cause of death?
O	w requir been si should	etec						24a. Was an	24b Were au	topsy findings available
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ita	ician: T certifical rector, p	Be (	25. Was case referred to medical					th (Check only one)		115 115
Ž	hysic this ca	၉	1 ☐ Yes 2 <b>(CN</b> )o	Hospital: 1 Inpatient 2 ER/Ou		it 3 DOA			ce 6 Other (Spec	cify)
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	To the Hospitel or At within 24 hours after of To tha Funerel Directompletely filled in by	edical (	29a. Certifier Check only one) Certifying Physics 2 Medicel Exam	ysicien: To the best of my knowledge liner: On the basis of examination an and manner stated.	e, deat	h occurred at the t vestigation, in my	ime, date and place opinion, death occu	, and due to the cau rred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0.1.	. ^	29c. Licen	se number	290	d. Date signed (Month	h, Day, Year)
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_	10			, M.D., 801 Tollh	ous	e Avenue	, D-1, Fr	ederick,	Maryland	21701
		ate	31. Date filed (Month, Day, Year)  MAR 2. 4 2004	32. Registrar's Signature	100	ميكا				

State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MARCH 20. 2004 MCKNIGHT 11:00 am /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 636 WILDWOOD PARKWAY BALTIMORE NA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5 Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M M 2 □ F APR. 13, 1940 63 SC Director 245-54-2388 Usuel Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinar must be codified at 1X Yes 2 □ No Director MD NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 636 WILDWOOD PARKWAY USA 1 and 2 should be filed within 72 hours after death w Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: AFRICAN Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ 3 ☐ Widowed 4 X Divorced AMERICAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 3 rd College (1-4or 5+) Ò CEMENT FINISHER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ORIE MCKNIGHT traumatic HAGER WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is.
any injury or other trau GLORIOUS GOINS (DAUGHTER) 636 WILDWOOD PARKWAY BALTIMORE, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) WESTERN STAR CEMETERY 3/ 27/04 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WYLIE FUNERAL HOME PA Man Min 638 N. GILMOR STREET BALTIMORE, MD 21217 23. Tar 1. Enter the disease, or implications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 K disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Monomall cell The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as onsequence of) Division of Vital Records, P.O. Box 68760, attending physicien Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) be detached 1 ☐ Yes 2 ☐ No the 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 X No 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 5 Pending investigation Injury 2 No within 24 hours after death. To the Funerel Director: 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely i (Check only one) To the 29b. Signatu 29d. Date signed (Month, Day, Year) CO. (Item 23a) (Type, Print) BACTITIONE, MD 21201 WIN IND 31. Date filed (Month, Day, Year) 32. R istrar's Si nature State Registrar MAR 2 4 2004

	1	For State Registrar	State of Maryl	and / Dep <i>Ce</i>	artment of F	lealth and Death		Reg. No.	. 05401
Physicia /Medica	n ai	1. Decedent's Name (First, Middle, 1	ANN	WA			Month	Day H 20	3. Time of Death 2004 18:42 M
Examine Funeral Director		079-52-2024	FALE MEDIC	ALCFA yrs. last birthday, 42 Yrs.	ron	If Under 24 Hrs Hours Min.	2. 8. Date of Bir	th y, Year)	nty of Death  A 2 F 0 A D  9. Birthplace (State or Foreign Country)  NEW YORK
Maryland f show	.	Usual Residence of Decedent  10a. State 10b. County  MARYLAND HARFOR		. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	Direc	10e. Street and Number 629 BURLINGTON	COURT		10f. Zip Code 21040			U.S.	
urs after	by Fur	11. Marital Status  1 □ Never Married 2€ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	E	Race - American Indian, Black, White, etc. Incify: BLACK
within 72 hours after ene. than "natural; or ite he Madical Examina	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12yrs	Education grade completed) College (1-4or 5+) 2yrs	(Give	dent's Usual Occup be kind of work done DO NOT use retired ATTENDAL	during most of wo	rking		f Business/Industry
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intiliole, integral year year, remit. Pages 1 and 2 should be spartment of Health and Menta portant: If tiem 27 is marked by Injury or other traumatic average.	17	John Nash/Husb 20a, Method of Disposition	and	629	Burlingto	on Ct., I		, Md.,	wn, State, Zip Code) 21040 on - City or Town, State
Deficiency  Pages Department of mportant: If it tny Injury or o		1 XBurial 2 □ Cremation 3 14 □ Donation 5 □ Other (Special Signature of Funeral Service Lie	cify) H	ARFORD N	Matory or other place MEM GARDEI  2. Name and Addre	vs   03-2	26-04	ABERD:	EEN, MARYLAND ME-HARFORD, P.A.
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The larate has	Completed						24a. Was autor perfo 1 - Yes	rmed?	b. Were autopsy findings available prior to completion of cause of death?     1 ☐ Yes 2 ☑No
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the state of the s	-	1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time of Injury	of 28c. Injur Wor	er: 4 Nursing F y at k? Yes 2 No	28d. Describe	now injury occ	ourred
DIVISION  DIVISION Attending within 34 house after death.  To the Funeral Director: After death.  completely filled in by the fune.	Certification:	3 Suicide 6 Could no 4 Homicide determin		At home, farm, st necify)	reet, factory, office	=	28f. Location (; City or Tox		mber or Rural Route Number,
Hospi 24 hour e Funer letely fill	Medical		Physician: To the best of my saminer: On the basis of exar and manner stated.						
To the Within To the	Me	29b. Signature and title of certifier	0		29c. Licens	e number		29d. Date sig	ned (Month, Day, Year)
6	1	30. Name and address of person w	To completed cause of death	(Item 23a) (Type		21809		MAR	cd 20, 2004
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Sta Registra		31. Date filed (Month, Day, Year)	32. Registraks S	signature	Aver 8 2				

		State of Maryland /  State of Maryland /	Department of Health  Certificate of Deat	and Mental Hygie	
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Charles W. N  4a. Facility Name (If not institution, give street and number)  Cood Sounan tan Hospital	lichols 4b. City, Town, or Locatio	2. Date of Death Month MQBCH	Day Year 3. Time of Death 18 200 y 13 13 PM 4c. County of Death N/A
Funeral Director		5. Social Security Number 6. Sex 1 7. Ag		der 24 Hrs. 8. Date of Birth	
Maryland a-f show	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, To           Maryland         N/A	own or Location Baltimore	e	10d. Inside City Limits
h with the	ai Director	10e. Street and Number 3131 Sumpter Ave	10f. Zip Code <b>212</b>		Citizen of What Country?
72 hours after death with the Maryland natural; or Itams 23a or 28a-f show Iteal Examited : ust be molified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No 1948  19€ Year or Dates: 1951	13. Was Decedent of Hispanic of If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☑ No Specify		14. Race · American Indian, Black, White, etc.  Specify: Black
- 29	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12	6a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired) Truck Drive	nost of working	b. Kind of Business/Industry  Perish Delivery
2 should be filed within and Mental Hygiene. Is marked othar than aumatic event, Ite Mark	To Be C	17. Father's Name (First, Middle, Last)  Charles Taylor			Nichols
O 00 00 00	ľ	19a. Informant's Name/Relationship (Type, Print)  Charles R. Nichols	9b. Mailing Address (Street and Nun 45 N. Catherine Street		·
		1) Burial 2 □ Cremation 3 □ Removal from State	o of Disposition (Name of etery, crematory or other place) on Forest Veterans Ceme	20,000,004	c. Location - City or Town, State Owings Mills , Maryland
permit. Page Department of Important: If any injury or		21. Signature of Fungral Service Licensee	22. Name and Address of Far Esten Brothers		1217
Medical Examiner (e pe executed Asician and Evainat-transit e puriat-transit	Examiner	23a. Part 1. Enter the disease, or omplications that caused the death. Deshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Secure Hally list randition of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence consulting in death) Last  Due to (or as a consequence consulting in death) Last	Septs  Septs  Seport:  Le ferse p  Co or):  Co or):	hlumoh	Onset and Death
the death certificate be every the attending physician ached for use as the buria	by Physician/Medical E	d	ath 3 □Ectopic pregnancy	r aceide	23d. Date of delivery  Month Day Year
he law requires tha e has been signed I	ompleted by P	Part II. Other significant conditions contributing to death but not resulting.  Diabeter mellit  Decebitus ula	ig in the underlying cause given in Pa cus , type 2 ers , dirwin	1 ☐ Yes  24a. Was an autopsy performs	24b. Were autopsy findings available prior to completion of cause of
To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Diractor: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Certification: To Be Co	27. Manner of eath    Natural   5   Pending   (Month, Day Year)   28	/Outpatient 3 □ DOA Other: 4 □ b. Time of Injury M 28c. Injury at Work?  M 1 □ Yes 2	lace of Death (Check only one)  Nursing Home 5 Residen  28d. Describe how  2 No  28f. Location (Stre	ce 6 Other (Specify) injury occurred et and Number or Rural Route Number,
spital or A burs after eral Dirac filled in by		4 Homicide determined 299. Place of mighty Actions  4 Homicide determined building, etc. (Specify)  299. Certifier (Certifying Physicien: To the best of my knowle		City or Town,	State)
To tha Hos within 24 hr To tha Fun completely	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and manner stated.  29b. Signature and title of certifier  MD  30. Name and address of person who completed cause of death (Item 23)	29c. License numb	death occurred at the time, dat	
' (		5601 Loch Rapen Boule	vard, Baltin	more , N.	<sup>7</sup> D
St. Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	forest.		

			For State Registrar		ryland / Depa <i>Ce</i>		lealth and M	lental Hygie		09257
-	Physici /Medio Examir	cal	1. Decedant's Name (First, Middle, La  4a. Facility Name (If not institution, giv	Vicora	2	4b. City, Nown, or	r Location of Death	2. Date of Death Month March	Day Year 2004 4c. County of Death	3. Time of Death
	Funeral Director		5. Social Security Number 214 12 2245 13 Usual Residence of Decedent	ex 7. Age 7. Age 83	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye July 8 1920	ar) 9. Birth Balti	inplace (State or Foreign unitry) Imore, Maryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel" or items 23e or 28e-1 show may injury or other treumatic event, it is Medical Examine triust be notified at once.	Funeral Director	Maryland Baltimore  10e. Street and Number  5207 Biddison Lane	City	10c. City, Town or Lo Baltimore	10f. Zip Code		10g. US	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No untry?
9600	iours after death irel', or Items 23	d by Funera	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	lispanic Origin? (Spi an, Mexican, Puerto <i>Specify</i> :			ite
121215-0036	fited within 72 h Hygiene. other then "natu ent, tre Modera	Completed by	15. Decedent's Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last,	completed)  College (1-4or 5+	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work d)	ing	tzler's	ndustry
Maryland	12 should be fi and Mental H I is marked ot reumatic ever	To Be	Harry Davis  19a. Informant's Name/Relationship ( John S Nicora (Son	Турв, Print)			Vivian D	Schmidt al Route Number, Cit	ty or Town, State, Zi	ip Code)
Baltimore, N	Pages 1 and Iment of Health tent: If item 27 jury or other to		20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control	Removal from State	20b. Place of Dispo cemetery, crea Metro Creme	atory Inc. N	March 22 200		Location - City or T timore, Mary	
Ball	permit. Departi Importi eny inj		21. Smature of Funeral Service Licer  23a. Part1. Enter the disease, or comshock, or heart failure. List only	ah Cho	the death. Do not en	(Ol Belair F	ral Home Inc Road Baltim	ore, Marylan	d 21236	Approximate Interval Between
68760,4	Examine be executed bhysician and street be burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):  consequence of):	dial e	Inte	rcfi		Onset and Death
P.O. Box 6	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  OHO 9  Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	⊒Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	very Day Year
Records, P	requir	þ	Part II. Other significant conditions of	contributing to death but	t not resulting in the u	inderlying cause give	en in Part I.			the cause of death?  bably 4 Gunknown  opsy findings available
Vital	Physicien: The law this certificate has t ral director, page 2 s	To Be Completed	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatien	t 2 DENOutpatier	nt 3□ DOA Othe	or	autopsy performed 1 Yes 2 4 (Check only one)	prior to co death? No 1 ☐ Yes	ompletion of cause of
Division of	Jing After fune	Certification; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b determined	28a. Date of Injury (Month, Day	Year) 28b. Time o Injury	f 28c. Injury Work M 1 🗇	y at k? Yes 2 □ No	28d. Describe how in 28f. Location (Street City or Town, St.	njury occurred	
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	(Check only 2 Medical Exer	nysicien: To the best of miner: On the basis of and manner state	examination and/or in	vestigation, in my of	pinion, death occurr	ed at the time, date a	and place, and due t	to the cause(s)
	To To con	2	29b. Signature and title of certifier  30. Name and address of person who	completed cause of de	ath (Item 23a) (Typa	29c. License	3P95	290. 7/10 - Losina 100	Date signed (Month,	0,2004
	Sta		31. Date filed (Month Day, Year)	del, 50		h Kave	n, B	A fine is	e MD	21239
	Regist	rar	2 ZU	FREDUR.	AS AM	CENT CONTRACTOR				

04-01943 Paul Ottinger

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State Unpend ITem#23a Registrar  1. Decedent's Name (First, Middle, La					2. Date of D	Death	3. Time of Death
Physici /Medi		Paul J.	Ottinger,	Jr.			March	18, 2004	1 <sup>Year</sup> 2138 P. M
Examir		4a. Fecility Name (If not institution, giv 3652 Marcy Creek			4b. City, Town Laurel		Death	Anne A	of Death Arundel
Funeral Director		199 01-9497	Gex 7. Age 1 2 F 7. Age	(In yrs. last birthday 25 Yrs.	Months Day		4 Hrs. 8. Date of B (Month, E) (07/27)	irth Dey, Year) /1978	Birthplece (State or Foreig Country)  DE
Maryland f ahow	or	Usual Residence of Decedent  10a. State  MD  Anne An	undel.	10c. City, Town or L	ocation Laurel				10d. Inside City Limit
with the	I Director	10e. Street and Number 3652 Marcey Creek R	oad		10f. Zip Code	20724	1	10g. Citizen of W	/hat Country? SA
s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Evaninal must be notified at	by Funeral	11. Marital Status  1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Control of Yes 2 XX		in? (Specify Yes or N Puerto Rican, etc.)	14. Race Black Specify:	e - American Indian, k, White, etc. White
within 72 ho iene. then "netur	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 54	(Giv	edent's Usual Occ e kind of work dor DO NOT use reti	ne during most ired)		16b. Kind of Bu	siness/Industry
should be filed void Mental Hygie marked other lumatic event, it	To Be Co	17. Father's Name (First, Middle, Last Paul J. Ottinger,	")				's Name (First, Middle Cynthia Re	le, Maiden Sumam	
and 2 shou balth and M n 27 is mar	-	19a. Informant's Name/Relationship Cynthia Ottinger /			ling Address (Stre		r or Rural Route Num ofare NJ (	ber, City or Town, : 08086	State, Zip Code)
permit. Pages 1 and 2 Department of Health Important: If Itam 27 I any injury or other tra once.		20a. Method of Disposition  1  Bunal 2  Cremation 3 5  4  Donation 5 Other (Special			oosition (Name of ematory or other p or Cemetery		Date /2004		City or Town, State
permit. I Departm Importal any injui		21. Signature of Eunera Service Lice 23a. Part1. Enter the disease, or con shock, or heart failure. List only	OSE Victor P.	1	501 Fast I	Stevens	Funeral Hon	P MD 21230	
Certificate be executed in the principle of the principle as the principle	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	ntoxication consequence of): consequence of):					Onset and Death
death certific e attending p id for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	Fetal death 3	□Ectopic pregnal			23d. Date Mor	e of delivery hth Day Year
as tha	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause	given in Part I.			ibute to the cause of death?
The law ate has be	Completed						24a. Wa aut per 152 Yes	opsy p	Vere autopsy findings availarior to completion of cause eath?  ✓ es 2 □ No
ilcian: certific rector,	Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpatie	ent 3CDOA	Other	of Death (Check only		or (Specify) ( COOPO)
ineri	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigator	28a. Date of Injury (Month, Day		of 28c. In	4 🗆 14 01	28d. Describe	how injury occurre	
D ff	tifica	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Inju- building, etc found:resi	ry - At home, farm, s . (Specify) dence	street, factory, office	C <del>e</del>	Cibe or T	Grand Contail	or or Rurel Route Number, , Laurel, P.G. Co
at at	Ç					time date and			
at at	edical		hysician: To the best o minar: On the basis of and manner sta	examination and/or	investigation, in m	y opinion, deat	TOCCUTION ACTUO CUTTO		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Cer	(Check only 20 Medical Exa	minar: On the basis of	examination and/or	investigation, in m		n occurred at the tune		(Month, Dey, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Irene 0 jala March 22, 2004 5:20 am 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cherry Hill Nursing Home Prince Georges Laurel 5. Social Security Number If Under 1 Year 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 N F Months Days Hours Min 80 319-20-2308 Yrs. Sept. 8, 1923 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery 1√ Yes 2□No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12512 Castleleigh Place 20904 United States 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2√□ No Specify: 3√Widowed 4 □ Divorced Specify white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary/Administration 1 State Highway Dept 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Bata Elizabeth Bata 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10506 Saddlebrook Court, Laurel, MD Sandy Ojala, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Chesapeake Crematory 3/25/04 Beltsville, MD 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center
1040 Rockville Pike, Rockville, MD 20852 21. Signature of Juneral Service Licengee 224. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) 8 Weeks CerebroVascular Accident Due to (or as a consequence of): Hypertension Over 1 Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1□ Yes XX No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No

**Physician** /Medical Examiner

5

**Physician** 

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

**Funeral** 

Director

r than "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at

with the Maryland

death

permit. Pages 1 end 2 should be filed within 72 hours after Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "naturel", or Ite

Baltimore, Maryland 21215-0020

Examine Physician/Medical ٥ Be

1 Natural 2 Accident

3 Suicide

29a. Certifier

one)

4 I Homicide

Completed 은 Certification:

27. Manner of Death

Medical

attending physician end for use es the burial-transit The law requires that the death certificete be executed P.O. Box 68760, signed by Division of Vital Records, ate has bage 2 s certificate or Attending Physician: efter death. Director

> State Registrar

To the Hospital or within 24 hours of To the Funeral Discompletely filled in

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number D0024721

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) March 23, 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4√ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Date of Injury (Month, Day Year)

S. Sadiq 14333 Laurel Bowie Road, Laurel, MD

31. Date filed (Month, Day, Year) MAR 2 4 2004 32. ∰gistrar's Signature It sports

2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

04 - 089

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	The state of the s
r	State of Maryland / Department of Health and Mental Hygieney

For	State of Maryland / Department of Health and Mental H
1 - For State Registrar	Certificate of Death

h	R	eg. No.	. 004	0 5	-	UU
	2. Date of Dea	th		3. Tirr	ne of D	eath
	Month	Day	2CO4	10	. E ∩	7. M

09260

1. Decedent's Name (First, Middle, Last) PEREZ 10NLS10 Physician MARCH 22, 2004 10:50 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY SINAI HOSPITAL 6. Sex 1 M 2 F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MARY -11-0866 Ιð Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene int: If Item 27 is marked other then "natural", or Items 23s or 28s-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28s-1 shov other traumatic event, the Medical Examiner must be notified at ALTIMORE 1 Nes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary (Secondary (0-12) College (1-4or 5+) UDENI STUDE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be VEREZ မှ e/Relationship (Type, Print BRANDMITHER 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State BACTIMOR MARYLAND / injury 4 Donation 5 Other (Specify) 22. Name and Address of Facility VANCHIN C. GREENE FUNELAR HIME 21. Signature of Funeral Service Licensee ROAD ORK BAUTO, MO UM 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? 1□ Yes 2□ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 DNO 3 Probably 4 Unknown Completed director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 17 Yes 2 □ No autopsy performed? Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1XYes 2 No 1 Inpatient 2X ER/Outpatient 3 DOA 2 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation est within 24 hours after death. To the Funeral Director: A 04 2 Accident 2 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, Sity or Tewn, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 Homicide BIK 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 23, 2004 O.C.M.E nd address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

**ORIGINAL** 

Registrar

			1 - For State of Many State of Many Registrar		partment of Health and ertificate of Death		ene2004 09261
	Physici		1. Decedent's Name (First, Middle Last)			2. Date of Death	Day Year 12:15 Am
	/Medio Examir		4a. Fecility Name (If not institution, give street and number)	In yrs. last birthday	4b. City Town, or Location of D	eeth	4c. County of Death  N/A
	Funeral Director		212-10-4503 1 M 2X F 84	Yrs.		Month, Day, 07/21/19	Yeer) 9. Birthplace (State or Foreign Country) Maryland
	yland now			Oc. City, Town or L	ocation		10d. Inside City Limits
	Ba-fat	Director	MD N/A		Baltimore Ci		1 ☐ Yes 2 ☐ No
	3a or 2	I Dir	10e. Street and Number 1449 Reynolds Street		10f. Zip Code 21230	10	ng. Citizen of What Country? <b>United States</b>
980	be filed within 72 hours after death with the Maryland tal Hygiene.  dothar than "natural" or Itams 23s or 28s-f show od othar than "natural" or Itams 23s or 28s-f show event, the Medical Evarrine must be notified at	by Funeral	11. Marital Status  1 □ Never Mamed 2 □ Married  1 □ Never Mamed 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 □ Yes 2∞No If Yes, Give Year or Dates:	er in U.S. 13	. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pi 1 ☐ Yes <b>3</b> √√ No Specify:	(Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specity: white
21215-0036	n 72 ho "natur edical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupation e kind of work done during most of DO NOT use retired)	working 1	6b. Kind of Business/Industry
212	d within giene. ar then	omb	Elementary/Secondary (0-12) College (1-4or 5+) 12 0		Clerical Secret		Courthouse
and		Be	17. Father's Name (First, Middle, Last)  JOSEPH Jawor			Name (First, Middle, M	
Maryland	and and Is m	To	19a. Informant's Name/Relationship (Type, Print)		ling Address (Street and Number of	Rural Route Number,	
	1 an Heal Heal		Margaret M. Konig / Daughter  20a. Method of Disposition		East Clement Street		D 21230  Oc. Location - City or Town, State
mor	of of		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify)		position (Name of ematory or other place) Le Veterans Cemetery		Crownsville MD
Baltimore,	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service Licensee Victor P. D	oda, Jr. (	22. Name and Address of Facility Narles L. Stevens F 1501 Fast Fort Avenu	uneral Home,	Inc.
10 (10 m)	Physician /Medical Examiner	ler	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	e death. Do not er			
x 68760,	death certificate be executed e attending physician and of for use as the bunal-transit	/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition of the cause). Due to (or as a condition of the c				
.O. Box	at the death of the by the attendached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown	Fetel death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
ords, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but n	not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Vital Records,	The ate h page	Completed				24a. Was an autopsy perform 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
Vita	8 8	o Be	25. Was case referred to medical examiner?  1  Yes	2 ☐ ER/Outpatie	Other	Death (Check only one)	
ion of	ding h. After fune	-	27. Manner of Death 1 Natural 5 Pending (Month, Day Ye) 2 Accident investigation			28d. Describe how	ce 6 □Other (Specify) vinjury occurred
Division	in the second	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (5	- At home, farm, si Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	Hospital 24 hours a Funerel I etely filled	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of example and manner stated	camination and/or in	th occurred at the time, date and planvestigation, in my opinion, death o	ace, and due to the cau courred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
	To the To the Complet	Me	29b. Signature and title of certifier	1	29c. License number	290	d. Date signed (Month, Dey, Year)
,	10		thomas y. Dry	nch	100 D491	76 N	larch 24, 2004
	\		30. Name and address of person who completed cause of death	Suite	907 Bal	Himore	2,MD 21202
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's MAR 2 4 2004	, Signature			

			1 - For State Registrar	State of Marylan	d / Depa	artmen rtificat	t of Hea e <i>of De</i>	alth and I	Mental Hyg	jiene No. No.	004	09262
4.	Physici /Medic		1. Decedent's Name (First, Middle, Last	Petro-	44				2. Date of Dea Month	Day	Year 2007	3. Time of Death
	Examin		4a. Facility Name (If not institution, give  Minuted Stay of 15  5. Social Security Number 6. Se	Newyland	last highday)	4b. City,	. Him.	cation of Death	-			n/a
	Funeral Director	}		2 F 72	Yrs.	Months		lours Min.	8. Date of Birth (Month, Day 5/01/1	931		place (State or Foreign htry) MD
	Maryland -f ahow lied at	tor	10a. State MD 10b. County N/A	10c. Cit	y, Town or Lo		ore Ci	ity			1	0d. Inside City Limits  TXXYes 2 □ No
	with the 3a or 28a	I Director	10e. Street and Number 1413 E. Clement	Street		10f. Zip	Code 21230	)	,	l0g. Citizer	of What Cour	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f ahow any righty or other traumatic event, Ira Madical Exaction must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Xwidowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? XXYes 2 □ No Ai: If Yes, Give Year or Dates:	s. 13. 17 Forc	Was Deced If Yes, spec E	lent of Hispa ify Cuban, M	nic Origin? (Splexican, Puerto pecify:	pecify Yes or No- p Rican, etc.)	14.	Race - Americ Black, White, pecify:	
Maryland 21215-0036	ithin 72 ho ne. nan *natur Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	fe completed)  College (1-4or 5+)	(Give	kind of wor DO NOT us	e retired)	ng most of won	king	16b. Kind	of Business/In	dustry
d 21	filed with Hygiene. other ther		12 17. Father's Name (First, Middle, Last)	0	Qua	alit <u>y</u>	Inspe		e (First, Middle,	Maiden Su	Manufac mame)	cturing
ylan	should be I ind Mental I i marked or umatic eve	To Be	Chrest Petroff					Kath	erine	Docki	ns	
Mar	and 2 sho ealth and n 27 ia m		19a. Informant's Name/Relationship (T) Ann Petroff / D						ral Route Numbel Baltimo			Code)
ore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tru		20a. Method of Disposition 1- Burial 2 ☐ Cremation 3 ☐ F	C	Place of Dispo	sition (Nam	ne of ther place)		Date	20c. Locat	ion - City or To	
	permit. Pag Department Important: I any injury o	- 1	4 ☐ Donation 5 ☐ Other (Specify)	, no.	Ly Cros		n • Ma d Address of	rch 23	, 2004	Ba1	timore	MD
<u>8</u>	permit. Departr Imports any inje	l g	23a. Part1. Enter the disease, or comp			OT EQE	t FORT	Avenue,	ral Home, Baltimore	MD ZL	230	
3	The law requires that the death certificate be executed  XEX  A Media  Ite has been signed by the attending physician and  age 2 should be detached for use as the burial-transit	dical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	uence of):							Interval Between Onset and Death
P.O. Box 6	that the death certificated by the attending placed by the attending placed for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of de 9 Unknown	Ideath 3	Ectopic pro				23d	. Date of delive Month	ry Day Year
rds, P.	quires that n signed by	þ	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the u	nderlying ca	tuse given in	Part I.	23e. Did tol			e cause of death? abfy 4 □Unknown
al Records,	: The law requir cate has been si , page 2 should	Completed							24a. Was a autops perform	n 2 iy ned?	death?	osy findings available inpletion of cause of
<u> </u>	s certifi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 🗆 DO	04		h <i>(Check only on</i> ome 5 ☐ Reside		Other (Specific	,)
Division of Vital	Attending Physician: r death. sctor: After this certifice by the funeral director, I		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury at Work? 1  Yes		28d. Describe ho			,
Divis	2 = = =	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory	office		28f. Location (St City or Town	reet and N n, State)	umber or Rura	l Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred a	at the time, di	ate and place, n, death occur	and due to the cared at the time, d	ause(s) and ate and pla	d manner as stace, and due to	ated. the cause(s)
-	To the within To lhe comple	Me	29b. Signature and title of certifier	/		29c.	License nur	mber	2	9d. Date si	gned (Month, I	Pay, Year)
	15		30. Name and address of person who co	modeled course of death (harm	230\ / (T	Brint'	111	165-	+	5	120/00	7
	1,,00		UMM'S 22-5. C.	rung 5%.	Balzin.		15 GW	201	Retice	a M.	NVIO, V	ND
1	Sta Registr		31. Date file (17), 2 4 2004	32. Registrar's Signa	ture	E.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 09263 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day tinder even 7:30AM 3-20-2004 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth KOKO Lane Baltimore MID If Under 1 Year | If Under 24 Hrs. 8 Date of Birth | Month, Day Year | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthptace (State or Foreign Country) 12M 2DF 215-46-5495 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f ahow 10d. Inside City Limits the Medical Examiner must be notified at MID Director Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2315 238 Ko Ko 21216 ane USA death tems 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 Ho
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after Black, White, etc 1 Never Married 2 Married altimore, Maryland 21215-0036 ò Black If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) 11+5 ustodian NA 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Depertment of Health and Mental in Important: If item 27 is marked or any injury or other traumatic avagues. Pages 1 and 2 should be Pinder Sc teven 2 Inez Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Pinder (wife) Juanita 2315 Koko Lane Balto. mo. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Green mount Crematary 3/29/04 Baito. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene SISI Baito Nat'L R Funeral Vaugh C Nat'L Rike Baito. MD, 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cancer Metastatic Lung, Liver olon disease or condition mos /Medical resulting in death) Due to (or as e consequence of): Examiner Renal failure WKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physicien and for use as the burial-transit Hypertension YR that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? t ☐ Yes 2 ☐ No 4☐ Pregnant at time of death Month Day Year signed by the a P.O. 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Anemia 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Neuropathy page 2 s 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed certificate Vital 90ut 2 No 1 Yes 2 No 1 Tyes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Lhis funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 X Natural 5 Pending Intury death. 2 Accident investigation 1 Yes 2 No Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C

completely filled i 29a. Certifier t 🔀 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) D 54749 2004

Reilly 31. Date filed (Month, Day, Year) MAR 2 4 2004 State Registrar

801 Toll House Ave, D-1, Frederick, MD 21701 32 Registrar's Signature CHASE !

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

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Physician  Model of Examiner  A South Form of the control of the c			_	State Registrar		Certifica	te of Death					26L
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Comparison of Spring and Time of Contribute to the cause of death?	BOX	ath ce	lan/	23b. Was decedent pregnant	1 ☐ Live birth 2 ☐ Feta	al death 3 ⊟Ectopic					,	Year
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			State of Maryland / Department of Health and  - State	Mental Hygi	ene 2004 09265
	Physicia	an	1. Decedent's Name (First, Middle, Last)  TOHN HARVEY PAYNE	2. Date of Death Month	Day Year i 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De		22, 2004 844 DM 4c. County of Death,
	Funeral Director		Maryland General Hospital Baltimor  5. Social Security Number  6. Sex  120   8 3512   T8 yrs.	in. (Month, Day,	Year) 9. Birthplace (State or Foreign Country)
	pu ≽		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	ith the Marylan or 28e-f show	Funeral Director	MD N/A BALTIMORE  10e. Street and Number 10f. Zip Code	10	1 ☑Yes 2 ☐ No
	eath with	eral Di	2401 GARRISON BOULEVARD 21216  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	USA 14. Race - American Indian,
036	urs after dea al', or Items	by	11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Pu 1 Yes, Sive Year or Dates:  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 Yes, Sive Year or Dates:	erto Rican, etc.)	Black, White, etc.  Specify: BLACK
Parine John Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, I'm Medical Examinar must be notified at 000s.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	working	6b. Kind of Business/Industry  GOVERNMENT
16 h	il Hygien other th	Be Con		lame (First, Middle, M.	aiden Sumame)
rylar	should by and Menta	TOE	HARVEY PAYNE  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or	HERINE Rural Route Number,	
e, Mg	1 and 2 Health a Nm 27 is ther treu		SELMA J. PAYNE/WIFE 2401 GARRISON BLVD  20a. Method of Disposition 20b. Place of Disposition (Name of	100	0C. Location - City or Town, State
) Jan	Pages ment of l ant: If its		1 ⊠Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Camson Forest	29/04 0	DWINGSMILLS MD
Balt	Depart Import any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREET 5151 BALTIMORE M	NE FUNER	LAL SERVICES E BAUTMOREMO 21229
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.		
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a Massive Hemogytysis  Due to (or as a consequence of):		
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)  Late of the Canal		
760,	ate be executed hysicien and he burial-transit	cal Exa	that initiated events resulting in death) Last  C. Pro of Consequence of:		
68	eath certificate attending phys for use as the		IF FEMALE: 23c If was outcome of premancy		23d. Date of delivery
P.O. Box	To the Hospitel or Attending Physician: The law requires that the death certifical within 24 hours after death. To the funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		Month Day Year
	w requires that the d been signed by the should be detached	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Peripheral Vascular Disease		acco use contribute to the cause of death?
of Vital Records,	The law requate has been page 2 shoul	complet	·	24a. Was an autopsy perform	prior to completion of cause of
Vita	ysician: ] is certifical director, p	To Be	examiner?	Death (Check only one	nce 6 Other (Specify)
	ding Physician: h. After this certific funeral director,		27. Mannyr of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 4 Work? 1 Natural 5 Pending 28a. Date of Injury 4 28c. Injury at Work?	28d. Describe how	
Division	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospitel or At within 2. hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place. On the basis of examination and/or investigation, in my opinion, death of and manner stated.		
	To the within To the compl	Me	29b. Signature and fittle of certifier 29c. License number 8950 7		d. Date signed (Month, Day, Year)
	`9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Genon	al Hos
i	Sta Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Rom I aco Marchan San Completed (Month, Day, Year)  32 Registrar's Signature  MAR 2 4 2004		

State of Maryland / Department of Health and Mental Hygier 🕦 🕦 🗓 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** March 2:24 RM Etta Pendleton 20 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 230-62-6913 1 □ M 2 🗓 F Yrs. Director 62 1941 14, Virginia Usual Residence of Decedent 10b County 10a State 10c, City, Town or Location 10d. Inside City Limits show r items 23a or 28e-f shov riner must be nutified at 1 Ty Yes 2 □ No Virginia Frederick Middletown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7883 Senseney Ave. 22645 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: other traumatic event, the Medical Exam Specify: 3 ☐ Widowed 4 \ Divorced Black "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Care Service 12 2 should be filed w and Mental Hygier is marked other th Care Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Louis Newman Catherine Virginia Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) current of Health a curant: If item 27 Is injury or other tra Margaret A. Myers (Daughter) 9502 Small Dr., Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Shenandeoah Mem. Park 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 3/25/04 Winchester, VA pernit.
Departn
Imports
any inju 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stover Funeral Home Mnew annis Strausburg, Virginia 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a con vivence of): Physician disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical use as the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 🗆 No of Vital 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) Medicas Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2003/1 30 Name and address of person who come leted cause of death (Item 23a) (Type, Print) Parkway Grunbett, mo 20770 31. Date filed (Month, Day, Your) 7305 Hanover 32 Registrar's Signature State MAR 2 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 20041 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Month Day **Physician** P DOROTHY WALKER PENSO MAR 2004 /Medical 4b City Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 24, 1914 Okfanoma 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 89 1 □ M 2 🖾 F 219-48-8970 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Eurnature. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Chevy Chase Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20815 122 Hesketh Street Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status ☐Yes 21 No 1 Never Married 2 Married White 1 Yes 2 XNo Specify: If Yes, Give Year or Dates: à 3 ™ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Walker Alice Frizielle Walker Charles Warren ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 13342 Foxhall Drive; Silver Spring, MD 20910 Penso / Daughter Martha 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Competer, crematory or other place)
Uniformed Services
University Health Sic. March 17,2004 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda, MD \* 4 
Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service theosee

MO0382

Rap Pruneral And Cremation 933 Gist Avenue Silver Spring shock, or heart failure. List only one cause on each line. Rame and Address of Facility Ramp Funeral And Cremation Services 933 Gist Avenue Silver Spring, MD Gist Avenue Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner the burial-transit attending physician and Due to (or as a consequence of): 99 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 XNo Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 🖂 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel of within 24 hours at To the Funerel D 1 CCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certified Medical

State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68768

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JAMES

a -

A. STOREY

32. Registrar's Signature

USNR

MO

MC

address of person who completed cause of death (Item 23a) (Type, Print)

LCDR

Sparker

G-83308 (CA)

29c. License number

29d. Date signed (Month, Day, Year)

NATIONAL NAVAL MEDICAL CENTER

8900 WISCONSIN AVE BETHESDA MD 20889

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 09268 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 7:30 a March 8, Glen. Edward Patty 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10715 Kings Riding Way Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 9, Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours XXM 2□F Wash., DC 44 Director 218-82-4218 Usual Residence of Decedent death with the Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Be Completed by Funeral Director Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3500 Nicholson Street 20782 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 Yes 2 Vo If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician 12 Electric permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth-any injury or other traumatic svent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Iris D. Aguiar Gordon E. Patty ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10715 Kings Riding Way, #102; Rockville, MD 20852 Iris D. Aguiar, Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3/12/04 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Baltimore Crematory at LP 21. Sign sure of Fun ral Service Licensee Simple Tribute Funeral and Cremation Center 1040 Rockville Pike Rockville, MD 20852 Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Non Small Cell Lung Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physician and ise as the burial-transi The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4√√Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No XXNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Special Esidence dire 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 2 this After this funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral C 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DC 10200 March 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Dennis Pirebat 110 Irving Street, N.W. Wash., DC 20010 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 4 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dey **Physician** Elbert March 18, Patterson 2004 10:56 am /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Shady Grove Adventist Hospital ROCKVILLE

If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer)

Nov. 19, 1 Montgomery If Under 1 Year Months Days 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral Months 1 → M 2 □ F 76 Wash., DC 577-32-0004 1927 Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23e or 28a-f show other treumstic event, the Modical Examiner must be notified at XX Yes 2 No MD Director Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 514 Longwood Drive 20850 United States by Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedenf Ever in U,S. Armed Forces? 11. Marital Stetus 1 X Yes 2 □ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes → No Specify: Specify: 1946 3 Nidowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mail Carrier HEW 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Patterson Daisy Carver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 ie eny injury or other treu once. Brenda L. Reiser/Daughter 904 Willow Run, Ormond Beach, FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1XXeurial 2 ☐ Cremation 3 ☐ Removal from State 3/20/04 Rockville, MD Parklawn Memorial Park 4 ☐ Donation S ☐ Other (Specify) 21. Signature of Fun ral Service Licentee 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike Rockville, MD Fant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 24 hours Seizures Examiner Due to (or es a consequence of): Physician/Medical Examine Alcohol Withdrawal attending physician and I for use as the bunal-transit Hospital or Attending Physicien: The law requires thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has blirector, page 2 s 1 TY55 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√xNo Certification: To htypatient 2 ER/Outpatient 3□ DOA : After this funeral 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation efter death Irector: A 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ក់ within 24 hours e To the Funeral I completely filled \*\*EXCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certified D58681 March 18, 2004 30. Neme and a ess of person who completed cause of death (Item 23e) (Type, Print) Dr Jude Alexander

**DHMH 16 Rev 6/95** 

State Registrar

31. Deteviled

Month, Day, Year)

**ORIGINAL** 

32. Registrer's Signature

9701 Medical Center Drive, Rockville, MD

		1_ For State	State of Maryland	/ Depa		ealth and M	fental Hyg	iene 2001	0927
		1. Decedent's Name (First, Middle, La	st)		timeate of L	Calif	2. Date of Deat	eg. 140.	3. Time of Death
Physic	ian		lle Pierne				Month	.9, 2004	9:42 PM
/Medi		4a. Fecility Name (If not institution, giv			4b. City, Town, or I	Location of Death	rater 1	4c. County of Deeth	9:42 FM
Exami	ner	322 Old Jop			Fallst			Harford	
Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
Director		089-16-6827	<b>½</b> <sup>M 2□ F</sup> 83	Yrs.	Months Days	Hours Min.	Month, Day, April 2		w York
D .		Usual Residence of Decedent	10a City	Town and					
aryla	5	10a. State 10b. County	Toc. City,	Town or Lo	cation			'	0d. Inside City Limits 1 ☐ Yes 2 No
he M	ecto	Maryland Harfor	d Fal	lston				On Citings of Mines Court	
n 72 hours after death with the Maryland "natural", or frems 23e or 28e-f ehow edical Experiment must be notified at	Funeral Director	10e. Street and Number 322 Old Joppa Roa	a		10f. Zip Code 21047			0g. Citizen of What Cour	itry ?
eath	era	11. Marital Status	12. Was Decedent Ever in U.S.	13		panic Origin? (Sp.		USA 14. Race - Americ	an Indian.
	F	1 □ Never Married 2 ☑ Married	Armed Forces?	1	Was Decedent of His If Yes, specify Cuban		Rican, etc.)	Black, White,	
within 72 hours after ene. than "natural", or Ite	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√7 No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify: Whi	te
2 hours af	Completed	15. Decedent's E. (Specify only highest gra		16a. Dece	dent's Usual Occupa	tion	ina	16b. Kind of Business/In	dustry
	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done du DO NOT use retired)	ning most of work	,,,d		
be filed with tal Hygiene. d other than	Con		4	Mech	anical En			U.S. Gover	nment
tal H d oth	Be	17. Father's Name (First, Middle, Last				18. Mother's Name			
	မ	Camille Charl				Teresa	(unk		
2 sh and is m		19a. Informant's Name/Relationship (			111.4000000000			City or Town, State, Zip	Code)
ges 1 and 2 should t of Health and Mer If Item 27 is marke or other traumatic		Robert Pierne - S		P.O.	Box 1011,	Edgewood	l, Maryl	and 21040 20c. Location - City or To	Ctata
		20a. Method of Disposition  1 XBurial 2 Cremation 3	Jrtemoval from State		sition (Name of matory or other place				
		`4 □Donation 5 □Other (Special			Mem. Park	3/23,	704 P	arkville, M uneral Home	aryland
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lines	nsee					uneral Home don, MD 210	
		230 Borth Enter the diseases or some	ge by wood the death						
Physician /Medical Examiner		23a. Part1. Enter the disease, or comphock, or heart failure. List on a limmediate Cause (Final disease or condition resulting in death)	a. Out to (or as a conseque	Verb	tie Car with He		Jular	Lescar	Approximate Interval Between Onset and Death
cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ence of):		0 (		U	
ite be executed ysician and ne burial-transit	cal	resulting in death) Last	Due to (or as a conseque	nce of):					
certifical rding physe as th	Med	IF FEMALE:						-	
death e atter	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	leath 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
that the sed by the detache	Y P	Part II. Other significant conditions	contributing to death but no result	ing in the u	nderlying cause give	Part I.	23e. Did tob	pacco use contribute to the	ne cause of death?
requires een sign hould be	d by	typorteu	seve Cardio	Vas	ulal a	teslar	Q 10Ye	es 2⊠No 3□Prob	ably 4 Unknown
law requir as been si 2 should	Completed	Molas	mu A				24a. Was a	n 24b. Were auto	psy findings available
The la	J L	7					autops	ned? prior to coi	inpletion of cause of
	ပိ	25. Was case referred to medical				26. Place of Deat		2 X No 1 ☐ Yes	2 L No
Physician: This certificater all director, p	To B	examiner? 1 ☐ Yes 2 DNo	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatie	Otho		-	ence 6 ☐Other (Specifi	v)
g Phys er this eral di		27. Mann of Death		8b. Time o	The state of the s			ow injury occurred	,,
Attending Fir death.	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigatio		Injury		es 2 No			
al or Attending s after death. il Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ne, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number or Rura n, State)	l Route Number,
To the Hospital or within 24 hours after To the Funeral Director Completely filled in the Comple	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my know miner: On the basis of examinatio and manner stated.	ledge, deat on and/or in	h occurred at the time vestigation, in my op	e, date and place, inion, death occuri	and due to the ca red at the time, da	ause(s) and manner as state and place, and due to	ated. the cause(s)
To the Vithin 2. To the Complete	Ž	29b. Signature and title of certifier	- ( )		29c. License			9d. Date signed (Manth.	Day, Year)
2		1 Straw 1	Do with		100	0/5/5	_	5/22/0	+
D	1	30. Name and address of person who Brian T. Yeo,	/ /			e Havir	a de Cus	ace MD 2107	8
	tate	31. Date filed (Month, Day, Year), MAR 2 4 20[	Registrar's Signatu		- Avenu	C, Havit	J GC GT	ACC IVID ZIUT	<u> </u>
Regis		MAR Z 4 20(	14 Bacca M	A	. A. S.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Glenmore (nmn) Proffit nan /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner anto Mariner Health If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 F Director 407-14-5060 March 6, 1917 Kentucky 87 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or Itema 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Harford Joppa the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 904 Pine Road 21085 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 XMarried 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White er than "nature". 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Crane Operator Steel Production 6 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental is marked Proffit Lyda 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Importent: If item 27 is any injury or other treu Bertha Proffit - Wife 904 Pine Road, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State 1 Surial, 2 Crematic 5/Dother (Specify) Crest Lawn Grdns of Mem. 3/25/04 Marriottsville, MD 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sign turn of F 23a. Part Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final diseas ) or condition resulting in death) recemone Physician day /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate couse. Entar Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, the attending physician hed for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? A) we are 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 202 No 1 Yes of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 SNatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by in by determined 4 Homicide the Hospitel 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20056607 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602. South Atwood Road, BELASR 21014 ANGELO, #106 JOSEPH 31. Date filed (Month, Day, Year) WAR 2 4 2004 32. Registrar's Signature State Registrar Soul

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH Sabina Radi1 19, 2004 /Medical 4a. Facility Name (If not institution, give street and number) NURSING 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BROOKE GROVE REHABILITATION AND CENTER SANDY SPRING MONTGOMERY | SANDY | SI | III | SI | SI | Date of Birth | (Month, Day, Year) | August 17,1908 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 F 155-18-0908 95 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Montgomery Sandy Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 13404 Slade School Road 20853 or Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Btack, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 □ Divorced Year or Dates natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Health Care Supervisor 12 other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any light or other traumatic event, since. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alexandra Kowalski John Stachelski 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Schmidt / Daughter 13404 Bartlett Street 20853 Rockville,MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Jersey City, NJ Holy Name Cemetery 4 Donation 5 Other (Specify) 21. Signature of Fune Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition Physician CONGESTIVE HEART FAILURE EARC /Medical resulting in death) Due to (or as a consequence of): Examiner DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events ARTERY Dua to (or as a consequence of). Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): the burialphysician Box 68760 Physiclan/Medical use as t the attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? to To Month Day Year 5 Other (specify) PO à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ MELLITUS 1 Yes 2 No 3 Probably 4 1 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge ideath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie (Check only the 29b. Signature and title of certifier 29c. License number D42046 STAFF PHYSICIAN 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (ITEM 238) (Type, FILLI)

GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDLY SPRING, MARY LAND 20860 39 Registrar's Signature 31. Date filed ( State Soul Registrar

			For State Registrar		State o	f Marylar		artmen rtificate				lental Hy	gien <b>©</b> (	004	092	73
	Dharist		1. Decedent's Name (Firs	t, Middle, Las	it)							2. Date of Dea Month	ath Day	Year	3. Time o	f Death
	Physici /Medic		Mary J.		Ros	sworm						March	19 2	004	4:20	рм
	Examin		4a. Fecility Name (If not in					4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Death		
			Charlestow					Ca If Under		vill If Under				altimo		
	Funeral		5. Social Security Number 723–14–7313	1	M 2∏xF	7. Age ( <i>In yr</i> s. 79	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day May 27	, Year) 1924	9. Birth	ntry)	or Foreign
1500	Director		Usual Residence of Dece									ray 21	, 1924	Mai	yland	
	yland		10a. State 10b.	County		10c. Ci	ty, Town or Lo	cation							10d. Inside C	ity Limits
	Mar.	ţċ	Maryland B	altimo	re		Cator	svill	.e						1 🗌 Yes	Ž∏ No
	or 28,	Director	10e. Street and Number				602	10f. Zip					10g. Citizen		•	
	23a	ai	715 Maiden	Choic	e Lane	Caton I			212					ited S	tates	
	tams	Funeral	11. Marital Status		Armed Fo	edent Ever in U rces?	J.S. 13.	Was Deced f Yes, spec	lent of Hi ify Cuba	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Ameri Black, White,		
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yla		<sup>L</sup> O	Frank Jone				4			Je	eanne	ette Rus	sell			
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	Healt Healt em 2 ther		Jeannette C		/ Sist	20b. I	Place of Dispo	sition (Narr	ne of			HR231	20c. Locatio			)
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Baltimore,	permit. Pag Department Important: I eny injury o	17	* 4 ☐ Donation 5 ☐ (			Chu	irch Če	meter Name and	Addres	s of Facilit		- 10				Tark
Ba	Dep Imp	9	> (thin	U	ZUNK						110	ubbard F me, Balt	unera.	L Home	, Inc.	1220
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Al C	Pnysician	5 60	Immediate Cause (Final	ire. Listonly	orige cause on e	/		- 13	2			1	_	13	Onset and	
	/Medical		disease or condition resulting in death)		a Due to (	or as a consec	quence of):	1 / 1	/C1 t	10-1	_/	15602	C		7/6/	16-2
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			1 - For State Registrar	State of	Maryland	d / Depa <i>Cei</i>	rtment of	Health of Death	and M	lental Hyg	iene	004	092	274
Ŀ			1. Decedent's Name (First, Middle, Las	t)						2. Date of Deat		V	3. Time o	f Death
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	/Medic Examin		4a. Fecility Name (If not institution, give		nber)		4b. City, Town	, or Location	of Death		<del></del>	unty of Death		
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	Funeral		5. Social Security Number 6. Se	ix i	7. Age (In yrs. Ia	ast birthday)	If Under 1 Ye	ar If Under	r 24 Hrs.	8. Date of Birth		9. Birth	place (State	or Foreign
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	Ma-f-	to	Maryland Baltimo	ce		В	altimor	е					1 L Yes	2 <b>X</b> No
	or 28	lre	10e. Street and Number				10f. Zip Code	θ		1	0g. Citizen	of What Cou	ntry?	
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	within 72 hours after death with the Maryland ene. then *netural; or Items 23e or 28e-f ehow the Madical Evannina must be multifud at	Funeral Director	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S	S. 13. \	Vas Decedent of Yes, specify C	of Hispanic Or	rigin? (Sp	ecify Yes or No- Rican, etc.)		Rece - Ameri Black, White,		
9	or Its	F	1 Never Married 2 Married	1 ☐ Yes If Yes, Give	2 <b>X</b> No		☐ Yes 2☐X						hite	
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Maryland	s. I and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23s or 28s-f show other traumatic event. The Medical Experiment must be rediffied at		19a. Informant's Name/Relationship (7				•			al Route Number				
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9	ges 1 t of t if its or ot		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □	Removal from S	State Ce	metery, crer	natory or other p	olace)						
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Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		1. Signature of Funeral Service Licen	1 D %	0		. Name and Ad		110	ibbard Fi				
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у			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that ca one cause on ea	aused the death. ach line.	Do not ent	er the mode of o	tying, such as	s cardiac	or respiratory arre	est,		Approxima Interval Be	tween
	Pnysician		Immediate Cause (Final disease or condition		ta	Muri	sons	1.2	1.271				Onset and	Deam
	/Medical		resulting in death)	Due to (	or as a consequ			4.1					1	3
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	D ==	ner	if any, leading to immediate cause. Enter Underlying	Dire to (	or as a nonsequ	ianca of):						1		
	nd rrans	Examiner	Cause (Disease or injury that initiated events	c										
Ó,	e exe ian a urial-	E	resulting in death) Last	Due to (	or as a consequ	ence of):								
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9	± O €	Med	IF FEMALE:								1000			
Вох	death certific e attending p id for use as	an/l	23b. Was decedent pregnant		come of pregnar inth 2  Fetal		Ectopic pregna	ncy			23d.	Date of deliv Month		Year
	ne dea the at	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna 9□Unkno	ant at time of de	ath 5□	Other (specify)	)				WIOTHI	Day	1001
P.0.	= 3° €	by Physician/Me	9 Unknown											
	w requires that s been signed I s should be det	by	Part II. Other significant conditions of		ath but not resu	Ilting in the u	nderlying cause	given in Part	1.			ontribute to t		
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ĕ	9 4 9	Completed								perform		death?		34430
<u>fa</u>		0	25. Was case referred to medical			<del></del>		26. Plac	e of Deat	h (Check only on	-			
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Division of Vital Records,	ding Physin. After this funeral di		27. Manner of Death	28a. Date o	of Injury h, Day Year)	28b. Time of	28c. lr	njury at Vork?		28d. Describe ho				
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ā	alor s afte il Dir	Certification:	4   Nomicide	Duildii	ig, etc. (Specify)	/				Only of Your	i, Siaio)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the	best of my know	vledge, deat	occurred at the	e time, date a	nd place,	and due to the ca	ause(s) and	manner as s	stated.	
	He Ho	edical	(Check only 2 Medical Exen	and mann		ion and/or in	estigation, in m	iy opinion, ae	ath occur	red at the time, d	ate and pla	ce, and due t	o the cause(	S)
	To the within To the Comp	ž	29b. Signature and title of certifier				29c. Lice	ense number				gned (Month,		
	./		1 Marclan	my Was			D-	405	21	-(	More	L176	2004	
	5		30. Name and address of person who	com leted caus	e of death (Item	23a) (Type,	Print) 77 F	2 W.	:14.	A		Suite		
			DR. OCHANO				221	Rout	1 )4mel	ma	21-	229		
	Sta	ate	31. Date filed (Month, Day, Year)		egistrar's Signat	nte	,	-	~ #I/ \I')		,			
	Regist		MAR 2 4 2004	Sepa	in the	y di	souls							

			For State Registrar	State	of Marylan	•	artment of H	lealth and N Death		giene Reg. No. 20 (	) 4	09275
			1. Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath		3. Time of Death
	Physici /Medio		Marie Rose Rhoo	des					Month		004	6 p M
	Examin		4e. Fecility Name (If not institution,	give street and nu	A A	р	4b. City, Town, o	Location of Death		4c. County of	_	
			Manner Head	th of	Bul A	11	Bel	Air		Harf	rd	
H	Funeral Director		5. Social Security Number 146-14-8871	5. Sex 1 ☐ M 252 F	7. Age (In yrs.	79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day May 11	v, Year)	Birthpla Counti PA	ace (State or Foreign ry)
	4-		Usual Residence of Decedent					1	ridy 11	, 1721		
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits
	Mar B-f st	ior	MD Harfo	rd	Ed	gewood						1 ☐ Yes 2 ☑ No
	or 28	ire	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Count	ry?
	th wi	Funeral Director	602 Pier Drive				21040			United S	tate	es
	r dea	nei	11. Marital Status	Armed F		.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	America White, e	
36	or It	by Fu	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, G	2 ⊠No ive		1□Yes 2☑No	Specify:		Specify:		
Ö	hours lural'	d b	3 152 Wildowed 4 Divorced	Year or I	Dates:	16a Daca	dent's Usual Occup	ation		16b. Kind of Busir	hite	
<u>1</u> 5	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show he Medical Exampher must be notified at	Completed	(Specify only highest	grade completed		(Give	kind of work done of NOT use retired	during most of work t)	ring	Own Home		15(I)
12	with iene. ther	m o	Elementary/Secondary (0-12)	College	(1-4or 5+)		maker			own nome		
D	be filed within 72 hours after death with the Marylan stal Hygiene. Individual than "natural", or Itams 23s or 28s-1 show other than "natural", or Itams 23s or 28s-1 show event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, L	ast)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)		
Maryland 21215-0036	2 should be and Mental is marked o	To B	Vincenzo Ingi	osi				Rose Mar	rie Mart	ucci		
ary	s 1 and 2 should f Health and Men item 27 is marke other traumatic	. 1	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Street	and Number or Rur	al Route Numbe	r, City or Town, Sta	te, Zip (	Code)
	s 1 and 2 of Health item 27 i		Mrs. Rose Ambro	se/Daugh				e, Edgewo	of the same of the	21040		
ore	of He	1	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation	3 □Removal from	State 20b. P	Place of Dispo cemetery, crei	sition (Name of natory or other plac	:e)	Date Mar 26	20c. Location - Cit	y or Tow	m, State
Ë	Pag ment tant:		° 4 ☐ Donation 5 ☐ Other (Sp.		- 1	altimo	e Nation		2004	Baltimor	e, M	ID
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or of		21. Signature of Funeral Service L	icensee mam	MO0382	22	Name and Address Cremation 8717 Gree	n and Fun	eral Alt	ernative Baltim	s	MD
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П	Physician		Immediate Cause (Final disease or condition	ΔΑ	ASTA	TIC 1	ung C	ANTED			L	Onset and Death
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$\nearrow$	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(05.05.0.00000	uanaa af);						
6	shade executed only sician and the burial-transit	E		Due to	(or as a conseq	dence or,						
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Вох	eath certifish attending p	clan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	Ideath 3	Ectopic pregnancy Other (specify)			Month		y Day Year
P.O.	the d y the	Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unki								
	es that igned b	by Pt	Part II. Other significant condition	s contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ite to the	cause of death?
Records,		d b							1 □ Y	es 2 No 3	] Proba	bly 4 Munknown
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Re	9 4 9	E							autop perfor	med?   dea	th?	pletion of cause of
Vital		e C	25. Was case referred to medical					26. Place of Deat			103 4	· Maria
>	N S	To B	examiner? 1 🗌 Yes 2 🏗 No	Hospital:	Inpatient 2	ER/Outpatier	t 3 DOA Oth	er: 4 ¥ Nursing Ho	ome 5 Resid	ence 6 Other	Specify)	
J of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mo.	of Injury nth, Day Year)	28b. Time o	28c. Injun Worl	y at		ow injury occurred		
<u>Si</u>	death. ctor: Al	atlc	2 Accident investig	ation			M 1 🗆	Yes 2 □ No				
Division	or Attending after death. Director: Afte in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Plac	e of Injury - At he ding, etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (S City or Tow	treet and Number ( n, State)	or Rural .	Route Number,
	urs a		Con Coddies 10 Codificing	Dhysician Tark		uuladaa daati						
	To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	xaminer: On the	ie best of my kno basis of examina nner stated.	wiedge, deat ition and/or in	roccurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time, c	ause(s) and manne date and place, and	er as sta	tea. he cause(s)
	within 2 To the comit le	Σ	29b. Signature and title of certifier	2			29c. Licens	e number	2	29d. Date signed (A	Aonth, D	ay, Year)
)	->-0		1 Man	MI.	21 M		1	35522		MARCH	23	2004
	1		30. Name and address of person w	ha completed cau				IDM -	141-1	- Internal	<u>ヘノ</u> IIII = 1	
	0.		MARK WIL	-d 2	NORTH		ENUE	BEL /	AIR 1	MAR, L	My	21014
S.	Sta Regist		31. Date filed (Month, Day, Year)	32. 2 4 2004	Registrar's Signa		la 1					
	riegist	C.I	MAK	5 4 LUU4	- Alexander		por for logo	Reka!				

Marie Rhodus

			1 - For State Registrar	State of Maryla	and / Dep <i>Ce</i>	artment <i>rtificate</i>	of He	alth an <i>eath</i>	d Mental F	lygier Reg. N	e 20 (	) 4	09276
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Eder-	/	Ritz			2. Date of Month	, 0	Day ZOC	ear	3. Time of Death 8/20 PM
	Examin		4a. Facility Name (If not institution, give s  Cood Saynary +90  5. Social Security Number 6. Sex	n Hospital	rs. last birthday	B <sub>\phi</sub>	trus.	ocation of D	MD.		c. County of		ace (State or Foreign
	Director		291-10-8001 1 Usual Residence of Decedent	M 2 1 F	91 <sub>Yrs.</sub>	Months	Days	Hours !	Hrs. 8. Date of (Month, Mar	Day, Yea 23, 1	912	Count NY	try)
	Maryland a-f show	ctor	10a. State 10b. County  MD Baltimor	1	City, Town or Lo							10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the a or 28 be not	Director	10e. Street and Number 8800 Old Harford F	Pond		10f. Zip 0					citizen of Wha		-
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.  If them 27 is marked other than "naturel", or terms 23a or 28a-f show it if term 27 is marked other than "naturel", or them 2 is a constituted or other traumatic event, the Machel Examiner must be notilised at	by Funeral		12. Was Decedent Ever in Armed Forces?  1 Yes 2 WNo If Yes, Give Year or Dates:		Was Decede	ent of Hisp by Cuban,	anic Origin Mexican, P Specify:	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Black, Specify:		an Indian, stc.
Baltimore, Maryland 21215-0036	d within 72 horgiene.  In Medical is	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 1 2	cation completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use etary	done dui		working		Kind of Busin	ess/Ind	ustry
yland	should be filed and Mental Hygi a marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Frank Eder					8. Mother's Albin	Name <i>(First, Mid</i> a Mach	dle, Maide	en Surname)		
Mar	od 2 sho lith and 27 is m	í	19a. Informant's Name/Relationship (Type Christopher Ritz/						<i>r Rural Route Nul</i> altimore			ite, Zip (	Code)
more,	permit. Peges 1 and 2 Department of Health s Important; If Item 27 is any injury or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)	amoval from State	Place of Dispo cemetery, cre Chesape	osition (Name matory or oth	e of ner place)		Date Mar 23 2004	20c.	Location - Cit ltsvil		
Balti	permit. Departm Importal any inju		21. Signature of Funeral Service License			2. Name and Cremat	Address tion	of Facility and F	uneral A	lter		s	
876 <del>0</del> ,	cate be executed /Medical Examiner sthe purial-transit sthe purial-transit	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	ct I				, 411631,			Approximate Intervat Between Onset and Death
O. Box 6	ne death certif the attending thed for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	□Ectopic preg □ Other (spec					23d. Date of Month		y Day Year
۵.	quires that the signed by ald be detacted	by	Part II. Dther significant conditions con	tributing to death but not r	_	nderlying cau	ise given	in Part I.	1	d tobacco		te to the	cause of death?
al Records,	ician: The law requir certificate has been si rector, page 2 should	Completed	/	/					24a. W au pe 1 U Yes	topsy normed?	prior	to com	sy findings available pletion of cause of
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Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, o	office		28f. Location City or 1	(Street a Town, Sta	and Number o	r Rural	Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only 2 Madical Examin	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at vestigation, ir	the time, n my opini	date and pi	ace, and due to the occurred at the time	ne cause( e, date ar	s) and manne nd place, and	r as sta due to t	ted. he cause(s)
•	To th To th compl	Me	29b. Signature and title of dentifier	1)//	1111	29c. l	License n	umber	10	29d. D	ate signed (N	fonth, D	ay, Year)
	{		30. Name and address of person who con	mpleted cause of death (It	23a) (Type,	Print)	(E-	300		1/10	1th 2	20,	2004
	Ψ		Michael A. Wilse 31. Date filed (Month, Day, Year)	MII	601 0	och 1	Rave	n 131	vel Bul	times	e 11/	7, 2	1239
	Sta Registr			4 200k	Race	4	1	10. 200	-				

		1	For State Registrar	State of M	arylan		artment of F		nd Mental Hy		2004	09277
Pi	nysicia		1. Decedent's Name (First, Middle, La						2. Date of D Month	Day		3. Time of Death
, I	Medic	al -	Willie Mabel F  4a. Fecility Name (If not institution, gi	leeb			4b, City, Town, o	r Location of	March	19 4c.	2004 County of Death	9:10 A.
E:	xamin	er	Genesis Eldercar				Randa1			В	altimore	
Fui	neral		Social Security Number     6.			last birthday)	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month, L	ay, Year)	Cou	
Dire	ector	-	238-09-4447 Usual Residence of Decedent		92	Yrs.			May 25	5, 19	ll Nort	h Carolina
yland	4		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 X No
e Mar	pellis	Director	MD Baltin	nore	<u> </u>	Wood1				10- 00	izen of What Cou	
with th	The D		10e. Street and Number	nn			10f. Zip Code	1244		Tog. Cit	USA	nuy r
death	CLUM	Funerai	8307 Windsor Mill 11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.			in? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Ameri Black, White,	
after			1 Never Married 2 Married	1 Tes 2T	<sup>No</sup> 19	45-	1 ☐ Yes 2 🗷 No		Tabita ( main, bio.,		Specify:	
1215-0036  within 72 hours after death with the Maryland ene.	al Ex	ed by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's B	Year or Dates:	19	46 16a. Dece	dent's Usual Occup	oation		16b. K	Mh ind of Business/Ir	i <u>ite</u> Idustry
<b>215</b>	Medic	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1-4or	5+)	(Give	kind of work done DO NOT use retire	during most d)	of working		Clothin	0
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and d be fill notal H	10 00 0	o Be	17. Father's Name (First, Middle, Las A.G. Thomas	()					Sylvania S			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	umati	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street		r or Rural Route Num			o Code)
and 2	n 27 ii ier tra		Pamela Rhodes/Dau	ighter	005 5		Ridge R		timore, MI		44 ocation - City or T	oum State
JOFE 10 TO H	or oth		20a. Method of Disposition  1 ▶ Burial 2 □ Cremation 3		1		osition (Name of matory or other pla	- 1				
Baltimore, permit. Pages 1 at Department of Hea	injury B.	14	* 4 □ Donation 5 □ Other (Special Signs of Funera Service Lice	1/	) WO		Cemeter		3/23/2004 Schwab Fu		timore,	
De de la	any ii		What the			7	36 Edmon	dson A	ve. Balt:	Lmore	т ноте, , MD 212	28
			23a. Part I. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each I	d the deat ine.		,			arrest,		Approximate Interval Between Onset and Death
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D	EW.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):						
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rtificat	ng phy a as th	-	IF FEMALE:									
Box 68 death certifica	ed by the attending ph detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	al death 3	⊒Ectopic pregnand ☐ Other (specify) _	ÿ			23d. Date of deliv Month	Pery Day Year
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Records, P. The law requires that	igned to	by Pl	Part II. Other significant conditions		1		inderlying cause gr		T.			the cause of death?
ord require	should I	eted	cerebro	743 C U	47		Clary	1/		Yes 2	T	bably 4 Unknown
Vital Records, stcien: The law requires t	has je 2	ompleted							per	opsy formed?	prior to co death?	opsy findings available ompletion of cause of
	o i	C	25. Was case referred to medical		<u>-</u>			26. Place	of Death (Check only		1 ☐ Yes	2 No
	S =	To B	examiner? 1 Yes 2 No			ER/Outpatie	nt 3 DOA	and the same of th	rsing Home 5 Re			fy)
O UC	After th funeral	ion:	27. Manner of Death  1 SNatural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inj (Month, D.	ury ay Year)	28b. Time of Injury	Wo	ryat ork? ]Yes 2 □ /	28d. Describ	e how inju	ry occurred	
Division of t or Attending Phy after death.	sctor:	Certification:	3 Suicide 6 Could not	ho l	jury - At h	ome, farm, st	reet, factory, office		28f. Location	(Street ar	nd Number or Rur	al Route Number,
Div tal or	al Dira ed in t	Cert	4  Homicide	bullding, e	ilc. (Speci	·y)			Only on 1	Own, State		
Hospital	To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Sertifying (Check only one) 2 Medicel Ex	Physician: To the bes aminer: On the basis and manner s	of examina	owledge, dea ation and/or in	th occurred at the to restigation, in my	me, date an opinion, dea	d place, and due to the th occurred at the time	e cause(s e, date an	) and manner as a d place, and due	stated. to the cause(s)
To the within 2	o the	Med	29b. Signature and title of certifier	and marmer's	tated.	1	29c, Licen	se number		29d. Da	te signed (Month	Day, Year)
<b>⊢</b> \$	- 0		1 fee	11.0	Zus	ley/	DO(	20964		Ma	arch 22,	2004
D			30. Name and address of person wh									
IV	CA.	ate	Jerome H. Ginsber	32 Regis			y Plaza N	1a11	Randallsto	wn, l	MD 21133	
	ی Reaist		31. Date filed (MAR 2 4 2	004	- د و د		rail e					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar		,	Cer	tificate of	Death	7	,	Reg. No	<b>.</b>	
			Decedent's Name (First, Middle, Last	it)			· · · · · · · · · · · · · · · · · · ·			2. Date of De	ath Da	y Year	3. Time of Death
	Physicia /Medic		Ber	tha Mae Ri	cketts					March	22,	2004	7:05A M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town	or Location	of Death		40	. County of Death	1
			407 Carl Street				Rockvi					Montgome	
	Funeral Director		5. Social Security Number 6. S 213-12-1598	ex 7. Age ☐ M 2 🖫 10	e (In yrs. last bi ) ]	irthday) Yrs.	If Under 1 Year Months Day		r 24 Hrs. Min.	8. Date of Bir (Month, Da July 2.	th Year)	9. Birth 902 Mar	nplace (State or Foreign Intry) yland
	pu »		Usual Residence of Decedent  10a, State 10b, County		10c. City, Tov	wn or Lo	cation						10d. Inside City Limits
	ehov ehov	č	Maryland Montgom	orv	Rocky								1 ☑ Yes 2 ☐ No
	the N	Director	10e. Street and Number	Cly	Rock		10f. Zip Code				10a. Ci	itizen of What Co	untry?
	with with		407 Carl Street				10.11.2.	20851				ited Sta	
	ns 23	era	11. Marital Status	12. Was Decedent		13. V	Vas Decedent of Yes, specify Cu			ecify Yes or No		14. Race - Amer	ican Indian,
326	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 le marked other than *natural', or Items 23a or 28a-f ehow empty injury or other traumatic event, the Marical Examinar must be notified at ODGe.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ ¹ If Yes, Give Year or Dates:			r Yes, specify Cu I□ Yes 2∏ N			Hican, etc.)		Black, White Specify: Wh	
Ş	2 ho	ted	15. Decedent's Ed (Specify only highest gra	ducation	168	a. Deced	lent's Usual Occ kind of work dor	upation	st of work	ina	16b. K	(ind of Business/l	ndustry
21	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	DO NOT use reti	red)	0. 0	9			
2	ygien ygien ver th		5			Sa1	es	10 14-41		/Fine 44indalla		partment	Store
Ē	be fill	Be	17. Father's Name (First, Middle, Last)							e (First, Middle		n Sumame)	
<u> </u>	should be and Mental I	2	Richard H. Gray	Time Print	10	h Mailie	Address /Stra			. Hause		or Town, State, Z	in Code)
a N	12 st h and 7 le n traun		19a. Informant's Name/Relationship ( Rosemarie Flanag									Marylan	
e,	1 and Heali em 2		20a. Method of Disposition	dir / I I I Circ	20b. Place	of Dispo	sition (Name of		March			ocation - City or	
Baltimore, Maryland 21215-0036	Pages nent of I ant: If Its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Potom	ery, cren	natory or other p Inited hurch Ce	motori	March 200		Pot	omac, M	aryland
	artme ortan injur		21. Signature of Funeral Service Licer		Method							ville, In	
ñ	Ded on the period of the perio		Il Masslette Bar	viat M	101305	300	Dert A. P West Mo	umpnrey ntgomer	y Aver	ue, Rock	ville	e, Marylan	d 20850–2805
	1,500		23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. Do	not ent	er the mode of d	ying, such a	s cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			eart	Failur	2					Onset and Death Months
Н	/Medical		resulting in death)	a	a consequence								
	Examiner		Sequentially list conditions,	b									
	sit s	Examiner	Sequentially list conditions, if any, leading to initing date cause. Enter Underlying Cause (Disease or injury	Due to (or as	а сипвириелов	a lotty:							
	ritificate be executed ing physician and a as the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of):						_	
90	be exician buria			,	,	,							
68760,	ficate physics the	Medical		. 0.						•	T-		
	rentifi nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Je					23d. Date of deli	very
Box	that the death ce ed by the attendid detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 □ Live birth 4 □ Pregnant at			]Ectopic pregnal ] Other (specify)					Month	Day Year
P.O.	t the by the	hys	9 Unknown	9□ Unknown									
of Vital Records, F	es De g	۵	Part II. Other significant conditions of	ontributing to death b	out not resulting	in the u	nderlying cause	given in Part	1.				the cause of death?  bbably 4 □Unknown
CO	law requir as been si 2 should I	Completed								24a. Was		24b. Were au	topsy findings available ompletion of cause of
R	The lavate has	Eo								perfe	ormed? 2 No	death?	2□ No
ital	ilcien: Th certificate rector, pag	0	25. Was case referred to medical					26. Plac	ce of Deat	h (Check only			
>	Physicien: r this certific ral director,	ToB	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1   Inpatie	ent 2 ER/C	Outpatier	nt 3□ DOA	Other: 4 🗆 N	lursing Ho	me 5 🕅 Res	idence	6 ☐Other (Spec	sity)
	ding Pt. J. After th		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 28b.	. Time of Injury	٧	Vork?		28d. Describe	how inju	ary occurred	
Sio	Attending r death. ector: After by the fune	catl	2 Accident investigatio					☐ Yes 2	_No	001 1	(0)		10
Division	or Attendated of the control of the country of the	Certification:	4 Homicide determined	28e. Place of In	iury - At home, ic. <i>(Specify)</i>	farm, str	eet, factory, offic	89		City or To	wn, Stat	nd Number of Hu te)	ral Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical Ce	(Check only 2 Medical Exa	nysician: To the best miner: On the basis o	of examination a								
	thin 2 the cape	Med	29b. Signature and title of certifier	and manner st	aidu.		29c. Lice	nse number			29d. Da	ate signed (Month	n, Day, Year)
)	¥ ₹ 8		1000		M.			4157				ch 22, 2	
•	$\mathcal{O}_{i}$		30. Name and address of person who	muleted cause of	leath (Item 23a	) (Type	_	++17/			riar	CII 44, 4	.004
	/	1	Ira Berger, M.D.					11. Ro	ckvi	lle, Ma	ry1a	and 2085	4
	Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature		M .	,	,		J		

			1 - For State Registrar	State of Maryland	-	artment of r tificate of		nental Hy	giene Reg. No. 20	04	09279
	Physici		Decedent's Name (First, Middle, Last,     Lilli					2. Date of De Month March	ath Day	Year 104	3. Time of Death 5:25 A M
	/Medio Examir		4a. Facility Name (If not institution, give Renaissance Garden	street and number)	_	4b. City, Town, o	r Location of Death		4c. County	of Deeth	
	Funeral Director		230-34-1000	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da January			lace (State or Foreign
Maryland 21215-0036	permit. Pegas 1 and 2 should be lifed within 72 hours after death with the Maryland Department of Health and Mental Highen. Department of Health and Mental Highen. Introduce 23s or 28s-f show any injury or other traumatic event, the Madical Examinal must be notified at once.	To Be Completed by Funeral Director		Road, Apt. 505  12. Was Decedent Ever in U.S. Armed Forces? 1   Yes 2 No If Yes, Give Year or Dates:  cation e completed)  College (1-4or 5+) 2	16a. Deced (Give life. L Secr	oring  10f. Zip Code  20904  Nas Decedent of Fives, specify Cuba  Yes, specify Cuba  Yes 2 No  Hent's Usual Occup  Hent's Usual Occup  NOT use retirect  etary	lispanic Origin? (Span, Mexican, Puerto Specify: lation during most of work 1)  18. Mother's Name Lois Mcdand Number or Runal	ing e (First, Middle, Guff <b>in</b>	Specify  16b. Kind of Bu  Investm  Maiden Surnam	Vhat Count  Sta  - America - America - Witte, white, white, white, white, white, white, white, white, which is in the state of the stat	od. Inside City Limits  1 □ Yes 2 No  try?  tes an Indian, etc.  hite  Justry  Banking
Baltimore, Ma	permit. Peges 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		Lee F. Roberts / H  20a. Method of Disposition  1 🛱 Burial 2 Cremation 3 R  1 Donation 5 Other (Specify)  21. Signature of Funeral Service License	usband 20b. Plac semoval from State Parkl.	3142 ( se of Dispos setery, crem awn Men	Gracefiel sition (Name of patory or other place norial Park	March	Apt. 50. Date 1 24, 4 1	5, Silver 20c. Location - Rockvill	Spring City or Too e, Ma	g, Maryland
760,	Physician and physician and bhysician and bhysician and physician and street transit street physician and physicia	ical Examiner	23a. Part 1. Enfor the disease, or complishock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Alzheimer's I  Due to (or as a consequent Hypertension  Due to (or as a consequent  Due to (or as a consequent	Dementince of):	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death 2 Years
Records, P.O. Box 68	by the attending pritached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1  Live birth 2 Fetel de 4 Pregnant at time of death	ath 3 🔲	Ectopic pregnancy Other (specify)	70.5		23d. Date Mon	of deliver	y Day Year
rds, P.	n signed by	by	Part II. Other significant conditions con	tributing to death but not resulting	ng in the un	derlying cause give	эл in Part I.		bacco use contri		cause of death?
		Completed						24a. Was a autop: perfor 1 ☐ Yes	sv Di	ere autop: for to come ath? Yes 2	sy findings available pletion of cause of
O E	After this	ation: To Be	25. Was case referred to medical examiner?  1	T	Outpatient b. Time of Injury	28c. Injury Work	at AM Nursing Hor	ne 5 🗆 Resid			
DIVISION	within 24 hours after death  To the Funeral Director:  Completely filled in by the f	edical Certification:	(Crack Cray 2   Medical Examin	28e. Place of Injury - At home building, etc. (Specify)	doe deam	oraniceo al the bio	a dala and dara s	City or Tow	auco(a) and man		
T off of	within 24 To the F complete	Medi	29b. Signature and title of certifier	rumana l	10	29c. License	number	2	ate and place, and place, and place	(Month, Da	ay, Year)
	Stat Registra		Loveen Puthumana, 31. Date filed (Month, Day, Year) MAR 2 4 2004		cefie		Silver S	pring,	Maryland	1 209	04

			For State Registrer	State of	Marylan	id / Depa	artme rtifica	nt of H te of L	lealth a Death	ind M	ental Hy	giene Reg. No	2004	09280
(4)			1. Decedent's Name (First, Middle, Las	)							2. Date of De Month	eath Dav	y Year	3. Time of Death
	Physicia /Medic		Charles E. Richar	dson						/	March	10		9:45 PM
	Examin		4a. Facility Name (If not institution, give	street and numi	ber)		4b. City	, Town, or	Location o	f Death		4c.	County of Deat	h
1		Ш	501 Dodson Drive					sing	Sun If Under 2	24 Urc	0.0 : (8:	(	Cecil	
	Funeral		5. Social Security Number 6. Se	x JM 2□F	. Age (In yrs.		Months	Days	Hours	Min.	8. Date of Bi (Month, D. )Ctobe	nn ay, Year)	9. Birt	hplace (State or Foreign
M. S. L.	Director		717-09-5850 Usual Residence of Decedent	^		88 Yrs.				Į.	ickobe	( 27	1913	Maryland
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. fnside City Limits
	Mary	to	MD Cecil		1	Rising	Sun							1 Yes 2 □ No
	r 28s	Director	10e. Street and Number					ip Code				10g. Cit	izen of What Co	ountry?
	h wit		501 Dodson Drive				1 2	1911				us	SA	
	deal	Funeral	11. Marital Status	12. Was Deced		.S. 13.	Was Dec	edent of Hi	ispanic Orig	gin? (Spe	city Yes or No	0-	14. Race - Ame Black, Whit	
õ	or its		1 ☐ Never Married 2 ☒ Married	1 Yes 2 If Yes, Give	es:WW II	7	1 🗆 Yes		Specify:					iite
2-003e	urai',	d by	3 Widowed 4 Divorced		es:WW II							101 10	Wi	
,	within 72 hours after death with the Maryland plane. Than "natural", or Items 23a or 28a-f show the Maurcal Examina must be natified a	Completed	15. Decedent's Ed (Specify only highest grad			16a. Dece (Give	kind of w	uai Occupa ork done d use retired	during most	of workin	ng	10D. K	ind of Business/	industry
7	fited withi Hygiene. other than	шc	Elementary/Secondary (0-12)	College (1-	4or 5+)	Max	inter	ance	•			7	own of	Risina Sun
0	Hyge ant,	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle		-	Nesseng Sun
<u>a</u>	should be nd Mental marked c	To B	Cleveland Hendric	rs Richa	vrdson				Rebe	гсса	Cutler	r Pie	rce	
	as 1 and 2 should of Health and Me litem 27 is mark rother traumating		19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Addre	ss (Street a	and Numbe	r or Rura	Route Numb	oer, City o	or Town, State, 2	Zip Code)
	and 2 salth n 27 l		Thelma M. Richard	son/Wife									ID 21911	
ore	of Ho		20a. Method of Disposition  1 KBurial 2 Cremation 3	Removal from S	tate	Place of Dispo cemetery, crea	matory or	other plac	(e)	03-22			ocation - City or	
Ē	Peges Iment of tant: If it		*4 □Donation 5 □Other (Specify	)	R.7	· Foar	d Fu	neral	e Home	2, P.	Α	Risi	ng Sun,	Maryland
Baltimore,	permit. Peges Department of important; if if eny injury or o		21. Signature of Funeral Service Licen		ordi	2 11	2. Name :	and Addres Que 6	ss of Facility 2n Str	yR.T. reet,	Foara Risin	l Fun 1g Su	eral Ho n, MD 2	me, P.A. 1911
П			23a. Part 1, Enter the disease, or composhock, or heart failure. List only	lications that ca	used the deat	th. Do not en	ter the mo	de of dyin	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a LEN	el Store	e Live	0	384-2						Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a conse	uence of):	7	Δ		~				
		_	Sequentially fist conditions,	b. Due to (o	MIC O	puence of):	VQ_	relie	many	DI	scase			
	ted nsit	nine	Sequentially fist conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	220 10 (0	. 45 4 55.155	1201100 01).								
7-	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (a	r as a consec	quence of):						1 - 1 - 1		
094	ate be executed only sicien and the burial-transit	dicai	(	d										
39	ntifica ing ph a as th	Med	IF FEMALE:			10.1								
Box	eath certific attending pl for use as t	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	al death 3		pregnancy	,				23d. Date of det Month	ivery Day Year
o.	The law requires thet the death certific ite has been signed by the attending plange 2 should be detached for use as	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9□ Unkno	nt at time of o wn	death 5L	Other (	specify)						·
ď.	thet the ed by detac	P.	Part II. Other significant conditions of	ontributing to dea	ath but not res	sulting in the u	ınderlying	cause give	en in Part I.		23e. Did	tobacco	use contribute to	the cause of death?
Records,	uires sign lid be		Caehexia		Hyp	others	elvon				13	Yes 2	□No 3□Pr	obably 4 Unknown
Ö	w require been signated should to	lete	Malmost		H	ano ten	Cie				24a. Wa	s an	24b. Were au	itopsy findings available
Ř	he law e has age 2 t	Completed	Machine Land			po rei	J(** C **				auto perf	ormed?	prior to death?	completion of cause of
ta	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical	3/					26. Place	of Death	(Check only	2∕∑ No one)	1 103	20110
<u> </u>	ysici is cer direct	To B	examiner? 1 □ Yes 2 🗘 No	Hospital: 1 ☐ In	patient 2	] ER/Outpatie	nt 3 🗆 [	Oth-	00				6 □Other (Spe	cify)
Division of Vital	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Certification: 7	27. Manner of Death  Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury , Day Year)	28b. Time of Injury	of M	28c. Injun Worl	yat k? Yes 2014		8d. Describe	how inju	ry occurred	
N S	Atten r deat ector: by the	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At h	ome, farm, st	reet, facto	ory, office		2	28f. Location City or To	(Street ar	nd Number or Ru	ural Route Number,
۵	pitel or ours afte eral Dir filled in		29a. Certifier 1 Certifying Ph				th Occurre	d at the tin	ne date an	d place a			<u> </u>	etatad
	n 24 hc n 24 hc he Fun oletely	Medical	(Check only 2 Medical Examone)	iner: On the ba and mann	sis of examina	ation and/or in	vestigatio	on, in my o	pinion, deal	th occurre	ed at the time	, date and	d place, and due	to the cause(s)
	To to To to	Ž	29b. Signature and title of certifier				2	9c. Licens	e number			29d. Da	te signed (Mont	h, Day, Year)
•	L		· Other	Cu				Do	0563	9.)			3/95/0	4
1	1		30. Name and address of person who		of death (Ite	m 23a) (Type	Print)	, 6		27 1 -	C-111			
	♥ \	ato	31. Date filed (Month, Day, Year)	1	gistrar's Sign	ature	or Hy	The str	· ste	3/2	Elly	en i	DIE (M	4-1
	Regist		MAR 2 4 200		w b	Los	S.							

		ŀ	4 101	artment of Health and Mental F	lygiene Reg. No. 2004 09281
			Decedent's Name (First, Middle, Last)	2. Date of	1109.110.
	Physici		Harry Clinton Sherman	Month March	$1.20^{\text{Day}}$ $2004$ $11:15 \text{ P}^{\text{M}}$
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Examin	lei	Mariner Health of Catonsville	Catonsville	Baltimore
	Euparal		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year If Under 24 Hrs. 8. Date of	
	Funeral Director		212–14–0415 <sup>1</sup> X <sup>M 2□ F</sup> 95 Yrs.	Months Days Hours Min. (Month, Jan. 2	
			Usual Residence of Decedent	vaii. 2	.o, 1909 Haryrana
	yland		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	Mar Ind	ţō	Maryland Baltimore Catonsv	ille	1 ☐ Yes 2 ☑ No
	1 the	Director	10e. Street and Number	10f. Zip Code	10g. Cilizen of What Country?
	30 o	O E	1502 Frederick Road	21228	United States
	Items 2	Jera		Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
9	or Ite	E	1 Never Married 2 Married 1 Yes 2 No		
Ö	ours a	by	3 ₹ Widowed 4 □ Divorced	1 ☐ Yes 2 X No Specify:	Specify: White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than Inatural', or Items 23e or 28e-f show ont, the Medical Examiner must be notified at	Completed by Funeral	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of working	16b. Kind of Business/Industry
21	thin Man	ple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
21	filed with Hygiene. Ither than	Son	5 0 Fore	man	Supply Company
nd	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Items 23e or 28e-f show other than matural Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	•
Maryland	2 should be filed within and Mental Hygiene. is marked other than eumatic event, the M	2	Harry Sherman	Rose War	ner
a	and is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural Route Num	nber, City or Town, State, Zip Code)
	5 = 7 = 1		Anna Shipley - daughter 810	4 Seawater Path, Columbi	a, Maryland 21045
ore	of Head of Head		20a. Method of Disposition 20b. Place of Disposering competery, cre-	osition (Name of Date matory or other place)	20c. Location - City or Town, Slete
Ĕ	Pag ent nt: I		1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	ark Cemetery 3/24/2004	Baltimore, Maryland
Baltimore,	그 된 본 근		21. Signatur of Funeral Service Licensee	2. Name and Address of Facility Hubbard	Funeral Home. Inc.
m	Depe Impo any is			4107 Wilkens Avenue, Bal	
<b>%</b>	70-0		23a. Part 1. Enter the disease, o complications that caused the death. Do not er shock, or heart failure. List only one dause on each line.	ter the mode of dying, such as cardiac or respiratory	varrest, Approximate
	Physician		Immediate Cause (Final	Di 10 De 110 Ti	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	age alman	a to
	Examiner		100	O distrike	70-0
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that lettered experts	2 3,000	
	uted d ansit	표	cause. Enter Underrying Cause (Disease or injury that initiated events		-
Ć.	n an ial-tr	Examine	resulting in death) Last Due to (or as a consequence of):		
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dicai	d		
9	g phys as the	edi	-		
Вох	eath certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	¬	23d. Date of delivery
m	death e atte d for	Physician/Me	1 Ves 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	Month Day Year
P.0	that the di ed by the detached	hys	9 Unknown		
	s that ned to e det		Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause giver in Part I. 23e. Di	d tobacco use coninbute to the cause of death?
rds	quires n sign	d b	- confrontstules	Gericliul. 10	☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
OS	w requir been s should	iete	0 10	24a. W	as an 24b. Were autopsy findings available
Records,	The lav	Completed by		au pe	topsy prior to completion of cause of death?
a		e C	25. Was case referred to medical	1 ☐ Yes	
of Vital		00	examiner?  1 Yes 2 No Hospital: 1 Inpalient 2 ER/Outpatie	26. Place of Death (Check onl	
	Phys r this ral di	. To	27 Manner of Death 28a, Date of Injury 28b. Time of	nt 3 DOA 4 A Nursing Home 5 He	esidence 6 Other (Specify) se how injury occurred
on	ding I h. After funer	to	1 Natural 5 ☐ Pending (Month, Day Year) Injury	of 28c. Injury at 28d. Describ Work?  M 1 Yes 2 No	o non anjury occurred
S	Attending ir death. ector: After by the fune	lica	3 Suicide 6 Could not be 390 Blace of lawar At home form of		(Street and Number or Rural Route Number,
Division	i to	Certification;	4 Homicide determined building, etc. (Specify)		Town, State)
	spite ours neral filled		29a. Certifier Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due to the	ne cause(s) and manner as stated
	24 h 24 h e Fus	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	vestigation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	₹	29b. Signature and title of centifier	29c, License number	29d. Date signed (Month, Day, Year)
	->-0		* A Soralians	771978	mars 0. /2 1/04
	2		30. Name and address of person who completed cause of death (ftem 23a) (Type	Print	The way of
	9		1101 mai den Chi =	Fano Collins	olub 5,000 9
	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	7	
	Registr		MAR 2 4 2004 Server	parks	

Stwert, Linua

			1 - For State Registrar	State of Maryla		artment of I			giene 1.eg. No. 20	04	09283
	Physici		1. Decedent's Name (First, Middle, L Mary L. Shumway	ast)		· · · · · ·		2. Date of Dea Month March		Year 2004	3. Time of Death 5:20 A M
	/Medic Examin		4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town,	or Location of Deatl	1	4c. County	of Death	
		•	Millenium Nursin	g Home Marley	Neck	Glen E	Burnie		Anne	Arun	del
	Funeral Director		235-52-5391	1 M 2 N E	s. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day Oct. 18	Year) 1917	9. Birthpl Coun Mary	ace (State or Foreign try) Land
	Maryland If show fied at	tor	Usual Residence of Decedent		City, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes Ž ☐ No
	r 28a	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
	th wit	aD	708 Washington A	venue		21060		1	United :	State	s
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-f show amy injury or other treumetic event, Ite M. dical Examinar must be mailted at ance.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		e - America k, White, e Whi	etc.
21215-0036	within 72 ho ene. than "netur fie M. dical	Completed	15. Decedent's (Specify only highest g		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	king	16b. Kind of Bu		
land 2	ild be filed lental Hygi ked other ic event, I	To Be C	17. Father's Name (First, Middle, Las William Vernon C	_			18. Mother's Nam Bessie (	ne (First, Middle,			
, Maryland	and 2 shoulaith and Market 27 is maler treumei		19a. Informant's Name/Relationship Carol A. Jacobs				t and Number or Rull Glen Bu			State, Zip 210	
Baltimore,	Pages 1 and of He ant: If item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Special Contents)	☐Removal from State	cemetery, crei	osition (Name of matory or other plants of Mem.	·		20c. Location - Elkridge		wn, State ryland
Balt	permit. Departr Imports any inj		21. Signatura Funeral Service Lic	ava	¥2	2. Name and Addr IrkTey-Ru 2I Crain	iddick Fu Highway	geral Hor	me P.A. en Burn	ie, M	1061 aryland
68760,	hysician and hysician and the burdal-transit	Ical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	equence of):	SCULA ART AL I	FR A EFY I +7PE	CCIDE	ENT BE USIO	- :	Approximate Interval Between Onset and Acetty S  2 YEARS 2 7 YEARS
P.O. Box 68	death certific e attending p id for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 0 0 0 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	⊒Ectopic pregnanc □ Other (specify) _	у		23d. Dat Mor	e of deliver	ry Day Year
rds, P	wrequires that the de been signed by the s should be detached	ρ	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause gr	ven in Part I.		_	ibute to the	e cause of death?
l Records,	2 5 3	Completed	HYPOTH	tyroIDI.	. M2	· · · · · · · · · · · · · · · · · · ·		24a. Was a autops perfori	ned?	rior to corr leath?	psy findings available apletion of cause of
/ita	cien: ertific actor,	Be (	25. Was case referred to medical examiner?					th (Check only on	18)		
on of \	ling Physicien:  After this certific: uneral director,	lon; To	1 Yes 2 No  27. Mann of Death 1 atural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Inju	ry at rk?	ome 5 Reside			1
Division of Vital	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be gen Blace of Injury At	home, farm, str		]Yes 2 □No	28f. Location (Si City or Town	reet and Number, State)	er or Rural	Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	Physician: To the best of my kraminer: On the basis of examinand manner stated.	nowledge, death nation and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the corred at the time, d	ause(s) and ma ate and place, a	nner as sta ind due to	ited. the cause(s)
	To th within To th comp	Me	29b. Signahus and title of certifier	ingh m.	Φ.	29c. Licen	5 1416		9d. Date signed	(Month, E	2004.
	5		34. Manual and address briperson who	completed cluse of fleath Nite	m 2 pay (Type)	RE A	-A RI	TCHII	EH	191	MAY,
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2	1 2004 Agents Sign	nature	5 don	Who !	,), (I)	2/2	~	

			1 - For State Registrar	State of Marylar			of H	ealth a			jiene _	004	0928	3 4
	Physici /Medic		1. Decedent's Name (First, Middle, Last Mildre							2. Date of Dea Month March 1	Day	Year 104	3. Time of Dea 4:29P	ath M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location of				unty of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		ш	Shady Grove Advent			16 Lladas 4		kville				tgomer	<del></del>	-
	Funeral Director		5. Social Security Number 6. Se 579-09-0557  Usual Residence of Decedent	x 7. Age (In yrs. 95	Yrs.	If Under 1 Months	Days	Hours .	Min.	B. Date of Birth (Month, Day, Sept. 5	,1908	Cour	olace (State or For ntry) ington, D	
	yland tow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Lin	mits
	the Mar 28a-f st	by Funeral Director	Maryland Montgome	ry	Montg	omery		lage		1	0g. Citizen	of What Cour	1 □ Yes 2 X	]No
	h with	a D	19310 Club House R	oad: Apt. 312		208	386				Unite	d Stat	es	
	- deal	ner	11. Marital Status	12. Was Decedent Ever in U				spanic Origin	n? (Speci	ify Yes or No- can, etc.)	14.	Race - Americ Black, White,	an Indian,	
900	ours after rai', or its Exemple		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 1 No If Yes, Give Year or Dates:		1 □ Yes 27		Specify:		our, oto.,		ecity: Whi		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show apply injury or other traumatic event. The Medical Exatic including the conflient and page.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done d	urina most d	of working		16b. Kind o	of Business/Inc	dustry	
	ted w tygier her th		5	(unle)	Swit	chboai							ernment	
Maryland	d be findal H	Be c	17. Father's Name (First, Middle, Last)	(ulik)						First, Middle, M	Maiden Sun	name)		
Ž	should nd Me mark	၉	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Mailir	ng Address (	Street a	Massie nd Number	or Rural F	Route Number	City or To	wn, State, Zip	<sup>Code)</sup> 20886	
	alth a		Elaine J. Mazzi/Da	ughter	10305	Watki	ns	Mill I	Drive	Mont	comer	y Villa	20886 are, MD	
ore	of He of He fitem r oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F		Place of Dispo	sition (Name	of	- 1	Dat		*	on - City or To		
Baltimore,	iit. Pag artment ortant; I injury o		*4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Litens	Ch	esapeal	ke Cre	mato	ory 03	/26/	2004 I	3eltsv	ville,	MD	_
Ba	Depa Impo eny ic		Centry S.	Dolle-	S 1	imple 040 Rc	Tri	bute I ille I	Tuner Pike;	al and Rockv	Crem ille,	ation (	Center 852	
į	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	DNAR			such as ca		1	est, Si∼≥∧S	3.5	Approximate Interval Between Onset and Death	
	*. *. '&. '&.	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec		-452	F	180	25 (60	14260	نه		-	
3760,	ate be executed hysician and the burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consected.		DCAG	20	AL	ini	PASCO	Coss			
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregni 1 Live birth 2 Feta 4 Pregnant at time of c	ıl death 3 □	Ectopic pred Other (spec					23d.	Date of delive Month	ry Day Year	
rds, P	quires that n signed b	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	nderlying cau	ise give	n in Part I.			acco use c		e cause of death?	
Record	fhe law requir te has been si age 2 should	Completed							_	24a. Was ar autopsy perform	y ned?	prior to con death?	osy findings availa	able of
Viital	ian: ] rtifica ttor, p	Be C	25. Was case referred to medical					26. Place of	f Death /6	1 ☐ Yes 2	DI No	1 🗆 Yes	212(NO	
<u></u>	Physici this ce al direc	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	ER/Outpatien	t 3 DOA	Other	-		5 ☐ Reside		Other (Specify	)	
Division of	Attanding Physician: r death. ector: After this certific. by the funeral director,	ation:	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	280 M	: Injury Work 1 🗆 Y	at	280	d. Describe ho				
Divis	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h- building, etc. (Specif	ome, farm, str	eet, factory,	office		281	Location (Str City or Town	eet and Nu State)	mber or Rurai	Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by	edical (	29a. Certifier (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exemi	sicien: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death tion and/or inv	occurred at restigation, in	the time	e, date and p nion, death	place, and occurred	d due to the ca at the time, da	use(s) and ite and plac	manner as sta e, and due to	ated. the cause(s)	
	To t To t comp	Ž	29b. Signature and title of certifier	0		29c.	_icense	number		29	_	ned (Month, L		
	V		30. Name an dress of person who co	ompleted cause of death //ten	n 23a) (Tune :		00	512	-හිට		3-	17-0	4	
			Anushiravan Dadga			•	r Dr	ive:	Rock	ville,	MD 20	850		
	Sta Registr	71.0	31. Date filed (Month, Day, Year)	32. Registrar's Signa										

			1 - For State Registrar	State	of Maryla	nd / Depa	artmen	t of H	lealth a	and Me	ental Hy	Heg. No.	200		
	Physicia	20	Decedent's Name (First, Middle, Last)				2. Date Mor					Day	3. Time of Death		
	/Medic	al	Luella	Be1		St	reet		. 13072		March		2, 2004 11:05 p <sup>M</sup>		
/	Examin	er	4a. Fecility Name (If not institution	-				Town, or onsvj	Location	of Death			County of Dea ltimore		
			Frederick Vi	6. Sex		s. last birthday)	L	r 1 Year	If Under	24 Hrs.	9 Date of Bir				
	Funeral		5. Social Security Number 217–16–4363	1 M 2 M F		Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da ept. 2	Y Year)	921 F.	rthplace (State or Foreign Country) Lorida	
- 0	Director		Usual Residence of Decedent		02					Ψ	cpc. z	, <b>,</b>	, 21 2.	101144	
	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow he Madigal Exemerante the multiped at		10a. State 10b. Count	/	10c. (	City, Town or Le	ocation							10d. Inside City Limits	
		tor	Maryland Balt:	imore	Ca	tonsvil	1e							1 ☐ Yes 2 🖾 No	
		lrec	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·		10f. Zip	Code				10g. Citiz	en of What C	ountry?	
		Funeral Director	6122 Wheatla	nd Road			2	21228	3			US	SA		
	dea	iner	11. Marital Status	12. Was D Armed	acedent Ever in Forces?	U.S. 13.	Was Dece If Yes, spe	dent of H	ispanic Ori In, Mexicar	igin? (Spec n, Puerto R	ify Yes or No ican, etc.)	- 1	4. Rece - Am Black, Wh	ericen Indian, ite, etc.	
98	or it	y Fu	1 Never Married 2 Ma	tf Yes,			1 ☐ Yes						Specify:	White	
8	urel	d by	3 Widowed 4 Divorce		Dates:			1.4.11.10			100		nd of Busines	c/loductor	
-5	be filed tai Hygi d other event, I	lete	(Specify only high	nt's Education est grade complete		(Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)  maker			t of workin	rking		id of busilies:	sindustry	
21215-0036		Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	Home							Own Hor	ne	
D 2		To Be Co	17. Father's Name (First, Middle	, Last)					18. Mothe	er's Name	(First, Middle,	Maiden :	Sumame)		
lan			William		В	e11			Lue1	la		(	Cunning	gham	
Maryland	2 should and Men ie marke		19a. Informant's Name/Relation	ship (Type, Print)		19b. Maiti	ng Addres	s (Street	and Numbe	er or Rural	Route Numb	er, City or	Town, State,	Zip Code)	
	and 2 valith in 27 in 27 in er tre		Carroll E. S	treet (Hu					l Road		tonsvi				
ore	permit. Pages 1 a Department of He Importent: If Item any injury or othe		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	3 Removal fro	- State	<ul> <li>Place of Dispose</li> <li>cemetery, cre</li> </ul>	matory or o	other plac		Da	1			r Town, State	
Ĕ			*4 □Donation 5 □ Other (	Specify)	Lo	udon Pa					04	Balt:	imore,	Maryland	
Baltimore,			21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Loudon Park Funeral Home  3620 Wilkens Ave., Baltimore, MD 21229												
	Physician /Medical Examiner		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	it caused the de									Approximate Interval Between	
			Immediate Cause (Final disease or condition a Pulmonam Edoma Onset and D								Onset and Death				
8			resulting in death)												
			Due to (or as a consequence of):  Concestive Heart failure												
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indicated events  C								].				
	be execut icien and burial-trar	xan	that initiated events resulting in death) Last	c. Due	to (or as a cons		0 0		1101	701		7			
760,	certificate be ending physicier ise as the buri	calE													
68															
Вох	nse use	2	IF FEMALE: 23b. Was decedent pregnant		outcome of preg		∃Ectopic p	rennancy	,			2	3d. Date of de		
	death he atten ed for u	sicle	in the past 12 months? 1 ☐ Yes 2 No	4□Pri	egnant at time o		Other (s)						Month	Day Year	
P.0	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be deteched for use as the burial-transit	Completed by Physiclan/Med	9 Unknown			···					22a Did tabassa usa santributa			1. No. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	
		by	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 ★Unknown					
Records,		ted	1463040160						163 2	2 10 3 Plobably 4 Ablikilowil)					
lec		nple	1200	nentic							24a. Was autor			utopsy findings available completion of cause of	
E E			Dy	phas	ia						1 Yes	2XNo		s 2 No	
Vital		Be	25. Was case referred to medic examiner?	Hospital				o. Oth	ar \	-	(Check only o				
ō	Phys r this ral dir	. To	1 Yes 2 No 27. Manner of Death		tnpatient 2	☐ ER/Outpatie 28b. Time of		3□ DOA 28c. Injun				5 ☐ Residence 6 ☐ O  Describe how injury occi			
On	To the Hospitel or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.	tlon	Manural   5   Pending   (Month, Day Year)   Injury   Work?												
Division		ifica								Street and	and Number or Rural Route Number,				
Ö		Certification:	4 Homicide Setermined building, etc. (Specify)  City or Town, State)												
		Medical (													
	To the To the Comple	Me	29b. Signature and title of certif				29	c. Licens	e number			29d. Date	signed (Mor	nth, Day, Year)	
	r s r ō		1250 lu	lix	PMG	un		05	503	03		3	124	124	
	10		30. Name and address of perso	n who completed o	ause of death (II	tem 23a) (Type	, Print)								
			ROPOLFO E	FERN	most	MOL	105	Fre	JEM	Cul r	CD STE	216.	2 . 2	1228	
	Sta Regist		31. Date filed (Month, Day, Yea MAR 2 4 2		. Registrar's Sig	nature	K)								

			1 - For State Registrar	State of Maryland /	Department of I Certificate of	Health and M Death	ental Hygien Reg. No	m 0 0 mg	09286		
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Las     A. Facility Name (If not institution, give		Stact 4b. City, Town,	OWSKA I	2. Date of Death Month Day  A  40	2 Year 2004 County of Deeth	3. Time of Death 0605 AM		
Ą.	Funeral Director		CIECIOWII			Hours Min.	8. Date of Birth (Month, Day, Year, June 8, 19	9. Birthr Cour 967 Pola			
e, Maryland 2121	he Maryland 8a-f show offilied at	ector	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A		own or Location				10d. Inside City Limits		
	23a or 2	Funeral Director	10e. Street and Number 208 S. East Avenue	•	10f. Zip Code 21224			itizen of What Coul pland	ntry?		
	Awithin 72 hours after death with the Maryland liene. Then "naturel", or Items 23s or 28s-f show the Mardical Examitrer must be civillied at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Specian, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.		
		To Be Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Utcher	during most of working	99	ail Food	•		
	should be filed nd Mental Hygi marked other umatic event, I		17. Father's Name (First, Middle, Last)  Jerzy Stachowski  18. Mother's Name (First, Middle, Maiden Sumame)  Sabina Macczak								
	d 2 th a tra		19a. Informant's Name/Relationship (T Patrycja Stachowsk		9b. Mailing Address (Street 8 E. Main Sti				•		
	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition  1 Burial 2 Cremation 3 :  '4 Donation 5 Other (Specify		of Disposition (Name of etery, crematory or other pla ew Crematory	3/22/0	04 Bal	ocation - City or To timore, I	Maryland		
Balt			21. Signature of Funeral Service Lifens	Miller	401 S. Che	ester Stree	et Baltimo		l Homes P.A land 21231		
Division of Vital Records, P.O. Box 68760,	Physician // Medical Examiner the prijal-transit	Examiner	23a. Part1. Enter the disease or comp shock, or heart failure. (1st only of disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.	LIVER LIVER LE PENCY Le of):	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death Year Months		
	death certific e attending p id for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	d		23d. Date of delivery Month Day Year					
	law requires that the as been signed by th 2 should be detache	Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc						co use contribute to the cause of death?  2 No 3 Probably 4 Unknown		
	To the Hospital or Attending Physician: The law is within 24 hours after deal or To the Funeral Director After this centificate has be completely filled in by the funeral director, page 2 sh						24a. Was an autopsy performed?	prior to cor death?	psy findings available mpletion of cause of 2 No		
		To Be	25. Was case referred to medical examiner?  1 □ Yes 2 No	Ho spital: 1 × Inpatient 2 ☐ ER/C	Outpatient 3 DOA	26. Place of Death	(Check only one) e 5 🗆 Residence	6 ☐Other (Specifi	y)		
		Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ury occurred						
		edical	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)		City or Town, State					
			29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
)		Σ	29b. Signature and title of certifier    Second Control of Certifier   29c. License number   29d. Date						te signed (Month, Day, Year)		
			30. Name and address of person who of Joseph Rahma.	1 0	100 North 11	lolfe Stra	et Balti	more, n	70 21287		
æ	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 4	32. Registrar's Signature	A books						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** March 22, 0750 Shirley Jean Stoyer /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Cecil Rising Sun 116 Turtleback Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 10, 1942 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 5. Social Security Number Funeral Days 1 M 20 F Yrs. Tennessee 61 Director 411-70-5646 Usuel Residence of Decedent filed within 72 hours efter death with the Marylend 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County 7 is marked other than "natural", or frame 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Rising Sun Maryland Cecil 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 116 Turtleback Court 21911 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0020 Specify. ۾ 3 ☐ Widowed 4 反 Divorced White Year or Dates Completed 16e. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 4 District Representative Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health end Mentel H tant: If item 27 is marked otl Be Mary Katherine Henderson DePew Walter (unk) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) nt of Health e 116 Turtleback Court, Rising Sun, Maryland 21911 Cara A. Stoyer / Daughter Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-23-04 Towson, Maryland Depertment Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart leilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) Aviedicat NAN PNIPI Examiner Due to (or as e consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of): Box 68760. Physician/Medicai that initiated events resulting in death) Last Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown Records, P. à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 110 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ dence 6 ☐ Other (Specify) Hospital: 201 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 27. M n Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attanding PI within 24 hours effer death.
To the Funeral Director: After the completely filled in by the funera Certification: Division 5 Pending Injury 2 Accident 6 Coutd not be determined 28e. Ptece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 C Suicide 4 Homicide 1 Ucritifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical (Check only 290 License number 29d. Date signed (Month, Dev. Year) 29b. Signature of person who completed cause of deeth (Item 23e) (Type, Print) 301 Shein 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		Certificate of Death		. No. 2 0 0 L	00200						
		1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death						
	Physician /Medical	Susan Grace Stubbs	Month March 18	8, 2004	0745						
4	Examiner	4a Facility Name (If not institution, give street and number)  4b. City, Town, or	Location of Death	4c. County of Deeth							
	<b>—</b>	14025 Travilah Road, Box 1414 Rockvil		Montgomer							
Maryland 21215-0020	Funeral	5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min	. (Month, Day, Y		place (State or Foreign ntry)						
	Director	Usual Residence of Decedent	Feb. 17,	1957 New	Jersey						
	yend More	10a. State 10b. County 10c. City, Town or Location 10d.									
	Man, Man, Man, Man, Man, Man, Man, Man,	Maryland Montgomery Rockville			1 ☐ Yes 2 No						
	or 28	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country									
	ath wi	14025 Travilah Road, Box 1414 20849	Uı	nited State	es						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and the notified at page.  To Be Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Married  2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer of Yes, Give the Yes, Give the Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of Note of Yes of	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify:							
	hour tural be	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	16	White b. Kind of Business/Inc							
	led within 72 hours a ygiene. Per than "natural", c tt, tra Medical Exer. Completed by	(Specify only highest grade completed)  (Give kind of work done during most of work in the state of the state	rking	b. Kind of Business/in	Justry						
	d with	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		Own Home							
	be file tal Hyg d othe event, Be C	17. Father's Name (First, Middle, Last)  18. Mother's Na	me (First, Middle, Ma	iden Surname)							
	Ment Ment arked aric e	James E. Knight Grace	L. Baum								
	2 sho and Is ma	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R									
e, 1	1 and Health m 27 ther t	Daniel L. Stubbs/Husband 14025 Travilah Road,  20a. Method of Disposition 20b. Place of Disposition (Name of									
Baltimore,	ages or of h	1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State Cemetery, crematory or other place)	March	c. Location - City or To	wn, State						
Ħ	it. Partmer	Crematorium, Inc.	23, 2004 E	Bethesda, N	laryland						
Ba	Depa Depa Impo any i	21. Signature (Funeral Service Licensee	0 West Mor d 20850-2	nitgomery Av 2805	renue						
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory arrest	,	Approximate Interval Between						
1	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Onset and Death  Due to (or as a consequence of):  b. HAPP I PLACEMIA  Due/to (or as a consequence of):  c. HAPP I PLACEMIA  Due to (or as a consequence of):  c. Due to (or as a consequence of):									
of Vital Records, P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner										
	res that the death cer signed by the attendir I be detached for use by Physician/A	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?  1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown								
	The law requires th rate has been signer page 2 should be d		24a. Was an a	1? ava	ere autopsy findings ailable prior to appletion of cause						
3ec	has by be 2 s				death?						
a			1 ☐ Yes	2 No 1 E	Yes 2010						
Χï	/\ D =	Hospital: Other:	ath (Check only one)								
of	Physic r this co sral dire	1 □ Inpatient 2 □ EH/Outpetient 3 □ DOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)									
Division	Attending In death. Sector: After by the fune.	27. Manner of Death   28a. Date of Injury   28b. Time of   28c. Injury at   28c. Natural   5   Pending   28c. Natural   5   Accident   28c. Natural   1   Yes   2   No	200 200 Et ion injuly obtained								
	of or Attend effer death Director: / d in by the tertificat	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	tal or Attending P is efter death.  al Director: After t led in by the funera Certification:	4 ☐ Homicide building, etc. (Specify)	late)	B)							
	To the Hospital or Attent within 24 hours effer deat To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier  Fathicia Tomsko May, MS 29c. License number  05/9/6	29d.	Date signed (Month, Darch 18)	ay, Year) 2004						
	,X	39 Name and address of person wife completed cause of death (flem 23a) (Type, Print)  MATTICIA TOMSKO NAYBA MONTROSE ROAD, ROC	kville,	MD 20	7852						
	State Registrar	31. Date filed (Month, Day, Year)  MAR 2 4 2004  MAR 2 1 2004									

DHMH 16 Rev 6/95

			For Stete Registrar	State of Marylan	d / Depa	artment of F	lealth and Death	F	Reg. No.	004	0000
)	Physicia /Medic Examin	al er	1. Decedent's Name (First, Middle, Las  ADELE 4a. Facility Name (If not institution, give  ANNE ARUNDEL MEDIC	street and number) AL CENTER		ANNAPOL			20, 20 4c. Cour	ARUND	
	Funeral Director		131-14-4640	7.4 60 5	78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	3. Date of Birth JUNE 14	, Year) 925	9. Birtho	place (State or Foreign
	e Maryland a-f show	ctor	Usual Residence of Decedent           10a. State         10b. County           MD         ANNE ARU		y, Town or Lo						0d. Inside City Limits 1 1 Yes 2 □ No
9800	within 72 hours after death with the Maryland ane. than "natural", or Itams 23a or 28a-f show ta Medical Examiner maal be notified at	by Funer	10e. Street and Number  7101 BAY FRONT DRI  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	VE APT. 401 S  12. Was Decedent Ever in U. Armed Forces?  1		10f. Zip Code 21403 Was Decedent of Hif Yes, specify Cuba	an, Mexican, Puer	Specify Yes or No-	Spe	Race - Americ Black, White, cify: WH	can Indian, etc.
21215-0036	Jwithin 72 h jiene. r than "nate toa Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed)  College (1-4or 5+)  OLLEGE 5+	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	rking	MEDIO	f Business/In	dustry
Maryland 2	be filed htal Hyg ed othe event,	To Be C	17. Father's Name (First, Middle, Last)		SPIEGL		EVA	me (First, Middle,		YUDIT	
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (7 WILLIAM SPIEGLER			ng Address (Street EST END A					
Baltimore,			20a. Method of Disposition  1  Burial 2 X Cremation 3   4 Donation 5 Other (Specify	Removal from State	emetery, cre LTOP S	esition (Name of matory or other place CC CC)	)RP. 3/2	22/2004	TOWSON	on - City or To	
Balt	permit. Page Department of Important: If sny injury of once.		21. Signature of Funeral Service Licen	Rul		2. Name and Addre				-	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any least 1 immediate.	a Due to (or as a conseq	Sep (		ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death 2 Y Www.s
8760,	icate be executed physician and s the burial-transit	dicai Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conseq  d.							
.O. Box 68	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	□Ectopic pregnancy	у			Date of delive Month	ery Day Year
<u>α</u>	quires that n signed by uld be deta	þ	Part II. Other significant conditions of Pany to p		ulting in the u	underlying cause giv	ven in Part I.		1.0		he cause of death? pably 4 □Unknown
of Vital Records,		Completed	Lymph	oma				24a. Was autop perfo 1 □ Yes		prior to co death?	psy findings available mpletion of cause of
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 爲 No	Hospital: 1 N Inpatient 2 □	ER/Outpatie	nt 3□ DOA Oth	200	ath (Check only o		Other (Specif	(y)
ion of	ding h. After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Injui	ry at rk? ]Yes 2 □ No	28d. Describe h	now injury occ	curred	
Division	or A	Certification:	3 Surcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		reet, factory, office		28f. Location (5 City or Tox		imber or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical		ysician: To the best of my kno niner: On the basis of examina and manner stated.							
	1	W	29b. Signature and title of pertifier	n Bech, MD		29c. Licens	, 46052	-		20/20	
	1/2		30. Name and address of person who	completed cause of death (Item	n 23a) (Type 01 Me	Print) ofical Pa	rkway,	annapo	los, M	10	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa		W					

State of Maryland / Department of Health and Mental Hygiene 2004 09290 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician March 18 12004 Martha Traynham /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Year If Under 24 Hrs. Hane 1th care If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 M XX Yrs. 93 Director 218-22-6809 VA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits s 23a or 28a-f show ust be notified at 1 X Yes 2 ☐ No NA Baltimore Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 1610 North Smallwood Street 21216 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 Specify: Specify: þ Black XXWidowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Balto. Country Club 8th grade na other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Mental is marked Jonas Lawson Mary Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 746 Linnard Street, Baltimore Md Barbara Cox-Neice 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ot
once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Arbutus Memorial 3/26/04 Arbutus, Md 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H West ala 21215 4300 Wabash Ave, Baltimore Md 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mumour **Physician** Wester disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner V2327 Julmencin on tructure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed certificate 1 Yes 2 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3□ DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director. filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies Quult 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Corton Avenue Bultimore, Maryland 21229 M) SCALGES 900 32. Registra's Sign 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Thomas Jackson Turner am 20a MARCH 22 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1021 DULANEY VALLEY ROAD TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Mar 30, 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 19 Colorado 548-93-3214 Yrs. Director Usual Residence of Decedent death with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Director NY New York 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examinat must be re 603 W. 139th Street, Apt. 4A 10031 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after rene of Health and Mentat Hygiene. ent: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 ☐ Married 1 Yes Chre Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College Elementary/Secondary (0-12) College (1-4or 5+) 2 Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael Doyle Turner Theresa Mary Kubasak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ms. Theresa Mary Kubasak/Mother 603 W. 139th Street, New York, NY 10031 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If Ite
any Injury or ot
once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Mar \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 2004 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives DEPOOM 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 1JC4 9 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physicien and the document that the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68750 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? signed by the at d be detached for 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2.00 No 3 Probably 4 Unknown 1 Tes Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate Yes 2 No Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 1X Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence & Other (Specify) at scene funeral 28a. Date of Injury (Marth, Day Yeer) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Natural death. 1 Tyes 2 Accident 2404 after death in rela 8-pes 3 Suicide 6 ☐ Could not be 28e. Place Injury - At home, building, etc. (Specify) farm, street, factory, office Location (Street and Number or Rural Route Number, City or Toym, State) 4 Homicide To the Hospital or within 24 hours af To the Funerel D wayous OU The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ZEMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifier Medical (Check only and manner stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME MARCH 23,2004 address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 M 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

2004

			1 _ For State Registrar	State of I	Marylar			nt of Hea <i>te of De</i>		Mental Hy	giene Reg. No.	2004	09292
E	Physici	an	1. Decedent's Name (First, Middle					<del></del> .		2. Date of De Month MARCH			3. Time of Death
	/Medic Examin	_	SAUL WIL.  4a. Facility Name (If not institution	LIAMS JR , give street and numb	er)		4b. City	, Town, or Lo	cation of Deati			County of Death	unknown
起油			5504 CEDONIA					TIMORI				N/A	
100	Funeral Director		5. Social Security Number 215-46-6147	6. Sex XXM 2□ F		last birthday) 6 Yrs.	Months Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da MAY 29	y, Year)	Cor	place (State or Foreign intry) H CAROLINA
	put 🛦		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Aaryla f sho	ō		/2				DE.					1 XYes 2 No
	r 28a-	Director	MARYLAND N  10e. Street and Number	/A	_,L	DA.	10f. Z	p Code			10g. Citi	zen of What Cou	intry?
	th with		5504 CEDON	IA AVENUE				21206	6		U	S.A.	
	tems	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	J.S. 13.	Was Dec	edent of Hispa ecify Cuban, N	anic Origin? (S Mexican, Puerl	pecify Yes or No o Rican, etc.)	)-	<ol> <li>Race - Amer Black, White</li> </ol>	
9	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Madical Examiner mat be notified at	by Fi	1 ☐ Never Married 2 X Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ∏ Yes 2∑ If Yes, Give Year or Date			1 🗆 Yes	2 XNo S	Specify:			Specify: BLA	CK
5-0036	2 hou		15. Deceden	's Education		16a. Deced	dent's Us	ual Occupation	n namest of we	rkina		nd of Business/li	
2	C * 3	Completed	(Specify only highe: Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT	use retired)	ng most of wo	rking			
2	filed within Hygiene. sther then "	Con	11th grade			TRU	CK D	RIVER	) ##=#==d= #1==	(First 84istalls		EVERY	
Maryland		Be	17. Father's Name (First, Middle,					18		ne (First, Middle			
ڇ	is 1 and 2 should be in the that the arth and Mental item 27 is marked of other traumatic ever	2	SAUL WILLIAM  19a. Informant's Name/Relations		-	19b. Mailir	ng Addres	s (Street and		MAE WIL:			p Code)
	and 2 seath ar n 27 is		MARY WILLIAMS/			55	04 C	edonia	AVenue	, Balti	more	Marvla	nd 21206
Ze,	of Heal of Heal fitem		20a. Method of Disposition			Place of Dispo	sition (Na	ame of		Date		cation - City or T	
altimore,	Pages ment of ant: If it ury or o		'4 □Donation 5 □ Other (S			TRO CR	EMAT(	ORY	03-	18-04	BALT	TIMORE,	MARYLAND
Balt	permit. Pages Department of Important: If it eny injury or o		21. Signature of Portra Story	Duollery					of Facility ROWN CO H AVENU	MMUNITY E	FUNI	ERAL HOM	E P.A.
4	8 8		23a. Part1. Boter the disease, or shock, or heart failure. List	complications that cau	sed the dea h line.						rrest,		Approximate Interval Between
. <u>34</u>	Physician		Immediate Cause (Final disease or condition	(00	dest	TVC I	hea	A +	achure				Onset and Death
6	/Medical Examiner		resulting in death)	Due to (or	a conse	quence of):							r-
		e.	Sequentially list conditions, if any leading to immediate	b. Due to jor	as a cons		hy						5 years
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
oʻ	e exection and an and and and and and and and and	Exa	resulting in death) Last	Due to (or	as a conse	quence of):							
58760,	ficate be executed physician and is the burial-transit	dical		d									
-	leath certific attending pl	0)	IF FEMALE:	23c. If yes, outco	me of pregn	ancy						23d. Date of deliv	re rv
Вох	death a atter d for u	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birt 4 ☐ Pregnan	t at time of		□Ectopic □ Other (s	pregnancy pecify)				Month	Day Year
о <u>.</u>	at the by the	hys	9 🗆 Unknown	9□ Unknow 							-1		
	The law requires that the death certif ste has been signed by the attending page 2 should be detached for use a		Part II. Other significant condition	ons contributing to deat	h but not re	sulting in the u	nderlying	cause given ii	n Part I.	23e. Did	١.		the cause of death? bably 4 Unknown
S	w requires s been si should b	lete	IM M HAD SUC	175500 X		renal	10	neala	H	24a. Was		24b. Were aut	opsy findings available
Re	ysicien: The lav is certificate has director, page 2 (	Completed			<del>/                                    </del>	Chal		· Spire	• 11	auto perfo 1 ☐ Yes	psy ormed? 2 XNo	death?	ompletion of cause of 2 No
<u>Zita</u>	icien: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:				Othor		ath (Check only	100		
o		- T	1 ☐ Yes 2 ② No 27. Manper of Death	1 □ Inp		ER/Outpatier				lome 5 X Resi			fy)
O	th. : After tuner	tlon	1 Natural 5 Pendir 2 Accident investi	g (Month,	Day Year)	Injury	М	28c. Injury at Work? 1 ☐ Yes	2 □ No			,	
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director,	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 200. Flace of	Injury - At h , etc. (Spec	nome, farm, str ify)	reet, facto	ry, office		28f. Location ( City or To	Street and wn, State,	d Number or Rui )	al Route Number,
	Hospitel of hours all Funerel D tely filled in		29a Certifier 1 Certifyir	g Physician: To the be	est of my kn	owledge deat	h occurre	d at the time	date and place	and due to the	Called(e)	and manner as	hatet
)	e Hospite 24 hours e Funerel letely filled	edical		Examiner: On the basi and manne	s of examin	ation and/or in	vestigatio	n, in my opini	on, death occu	irred at the time,	date and	place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	11	n a +			Oc. License nu			29d. Date	e signed (Month	Day, Year)
	2		1 y stolena	Kin	MD				-00		Ma	rch 1	7 2004
1	18/1		30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type,	Print)		10	110 0	1-4	A	yard 21287
{	Sta	ato	31. Date filed (Month, Day, Year)	いつ (CC) (2 32. Ran	istrar's Sign	ature/	67	MTET -	- WING!	110 0	IInn	10.2/16	yland 21287
	Registi		MAR 2	4 2004	THE WALL	S. K	304	U					

Registrar

State

111 Penn Street, Baltimore, Maryland 21201

parkers

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 2 4 2004

RUBIO

, M.D

32. Registrar's Şignature

Degara

ANA

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 () () [

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 18 2004 11:44 AM March Willie Beatrice Walls /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Harbor Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 30, 1925 Birthplece (State or Foreign Country)
 C. 5. Social Security Number **Funeral** Days Hours Min 1 ☐ M 2 🗷 F 213-20-3194 78 Vrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State or 28a-f show X 1∏Yes 2∏No the Mudical Examiner must be notified at Baltimore N/A Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21225 3066 Ascension Street 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify: 0 Specify Maryland 21215-0036 ۵ 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education iges 1 and 2 should be filed within 72 land Health and Mental Hygiene. If item 27 is marked other than "nate during most of working (Specify only highest grade completed) Church College (1-4or 5+) Elementary/Secondary (0-12) Minister (Elder) 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leola Gillian George W. Harding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3066 Ascension Street Baltimore, Maryland 21225 Charles Walls Husband other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20c Location - City or Town, State 20a Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 03/24/04 9 Department of Important: If any injury or once. Loudon Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Home P.A.
1300 Eutaw Place Baltimore, MD 21217 21. Signature Fural Service Licenses permit. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ears rerioscleratio Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Pars 4usion 21 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last (as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 PNo the 9 Unknown Ö 9 Tilnknown signed by a. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 12 No 1 Yes Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 - Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) im ore, 072 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 4 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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10a. State

Maryland

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Completed

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Examiner

Physician/Medical

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Certification:

Medical

IF FEMALE:

5. Social Security Number

10e. Street and Number

12

Lucunda Duffin 20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

in the past 12 months?

☐Yes 2☐No

9 Unknown

1 Yes 2 No

27. Manner of Death

Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

disease or condition resulting in death)

lu

212-48-3550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Allen M. White Pay 01:24xm 2004 arch 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltiman Hospital of Baltimore Cit If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month Pay 947 Birthplace (State or Foreign
 New York Min. Days **1X** M 2 □ F Hours 56 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore N/A 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? U.S.A. 10f. Zip Code 21215 4806 Liberty Height Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1x Never Married 2 Married Black 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Park Garage Elementary/Secondary (0-12) College (1-4or 5+) Chauffer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Ada Henson Allen M. White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4711 Dartford Ave Baltimore, Maryland 21229 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, Maryland 03/23/04 King's Memorial Park 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Home P.A.
1300 Eutaw Place Baltimore, MD 21217 Approximate Interval Betweer Onset and Death Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, the antiquity one cause on each line. Sepsis

Due to (or as a consequence of): CYSCH Due to (or as a consequence Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Baltinore

2 □ No

RES-000

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

March 17, 2004

**Funeral** Director ?7 is marked other then "netural", or items 23e or 28a-f show treumatic event, the Medical Examinar must be motified at within 72 hours after 1 and 2 should be filed with Health and Mental Hygiene. : if item 27 is or other tre Pages 5 permit. Page Department of Important: if any injury or once.

20th ent Known as

**Physician** 

/Medical

**Examiner** 

Physician /Medical **Examiner** 

The law requires that the death certificate be executed physician and is the burial-trans Box 68760. the attending p use as þ been signed be should be deta certificate Vital ot filled in by the funeral After To the Hospital or Attending

death.

Director:

within 24 hours after To the Funerel Direct

P.O. Records,

Division

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seger MD 31. Date filed (Month, Day, Year) MAR 2 4 2004

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

Sinai Hospital of #32. Registrar's Signature

and manner stated.

ORIGINAL

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 9:34p Wesley 20 2004 Roosevelt Freddie 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) NA Genesis Elder Care Homewood Baltimore If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7-20-35 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1⊠M 2□F Yrs. S.C. 248-48-1850 68 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Yes 2 No Md. NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21212 6814 Sturbridge Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Thomkey Aluminium Co. Steel Worker 6th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Davis Wesley Frank Fannie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6814 Sturbridge Dr., Baltimore, Md. 21212 Sister Pauline Bell 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 3-24-04 4 ☐Donation 5 ☐ Other (Specify) Mt. Carmel Cem. Dundalk, Ma. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovaicular Due to (or as a consequence of): Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical **Examiner** 

physician

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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ral', or items 23s or Examiner must be

"Instural" or than "natura".

other 7 is marked othe treumatic svent,

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other treumatic sysnigore.

Director

Completed by Funeral

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death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

burial-transit Physician/Medical by Completed Be 은 After the al or Attending P s after death. I Director: After I d in by the funera Certification: To the Hospitel within 24 hours a To the Funerel Completely filled in

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

IF FEMALE: 23b. Was decedent pregnant 25. Was case referred to medical

1 Yes 2 No

5 Pending investigation

6 Could not be determined

Mar-Door Kirown

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 / Homicide

29b. Signature and title of certifier

1. Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 1No 26 Place of Death (Check only one

			-		. ( 0.110 011 0711)		_
pital: 1   Inpatient 2	ER/Outpatient	3 DOA	Other:	4. Nursing Ho	me 5 Residence	6 ☐Other (Specify)	
28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	injury at Work? 1  Yes		28d. Describe how inj	ury occurred	
28e. Place of Injury - At h building, etc. (Specia	ome, larm, stree (y)	et, factory, of	fice		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Balt more

29c. License number 931865 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cutau Street 821 206 31. Date liled (Month, Day, Year) 32 Registrar's Signature

State Registrar

Medical

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

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			State of Maryland / Department of Health and Mental Hygiene Certificate of Death  State Reg. No. 2004 09297
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year MARCH 19, 2004 6:30 A M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  FREDERICK MEMORIAL HOSPITAL  FREDERICK  FREDERICK  FREDERICK  FREDERICK  FREDERICK  9. Birthplace (State or Foreign
	Funeral Director		217-80-7053 1 M 2 F 87 Yrs. Months Days Hours Min. Sept. 10, 1916 Maryland  Usual Residence of Decedent
	a-f show	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Prederick Frederick 10d. Inside City Limits 1
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 11 South Jefferson Street 10f. Zip Code 21701 10g. Citizen of What Country? U.S.A.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or Itams 23a or 28a-f show mith injury or other traumatic event, Ira Madeal Examinar must be multiped at ance.	by	11. Marital Status  1 Never Married 2 Married 3 Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  16. Yes 2 No Specify: Specify: White
21215-0036	within 72 ho jene. r than "netur Ire Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker  Own Home
and	ild be filed lental Hyg ked otha ic event,	To Be C	17. Father's Name (First, Middle, Last)  Harvey Maurice Stockman, Sr.  18. Mother's Name (First, Middle, Maiden Sumame)  Anna Mary Ringel
Mar	2 sho and is m		19a. Informant's Name/Relationship (Type, Print)  Mrs. Patsy A. Young, daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1504 Rock Creek Drive, Frederick, Maryland 21702
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tr once.		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  210b. Place of Disposition (Name of cemetery, crematory or other place)  210b. Place of Disposition (Name of cemetery March 22, 2004 Middletown, MD)
Balt	permit. Page Department of Importent: If any injury of QDC8.		21. Signature of Funeral Service License MOO255 MOO255 Past Church St., Frederick, MD 21701
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death Onset and Death
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s, P	es bed	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
al Record	The law ate has t page 2 s	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No
ion of		ation: T	27. Manner of Death  1 Actival 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  M 1 Yes 2 No
Division	orlA after Direction by	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital within 24 hours a To the Funeret I completely (illed	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	To the within 2	M	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  3-19-04
_	4		30. Name and address of person who person wh
F 10	Sta Regist		31. Date liled (Month, Day, Year) MAR 2 4 2004  32. Registrar's Signature

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V	Examin		4a. Fecility Name (If not institution, giv 402 BRESL				4b. City, Tow	m, or	Location of Death			4c. County of		2)
	Funeral		5. Social Security Number 6. S	iex 7. Ag	e (In yrs. las		If Under 1 Y		If Under 24 Hrs. Hours Min.	8. Date	of Birth h, Day, Ye			lace (State or Foreign
	Director		217-22-9663 Usual Residence of Decedent	<b>∑</b> M 2□F	76	Yrs.	istorial 5			May	16, 1	1927 N		land
	aryland ehow d at	_	10a. State 10b. County			Town or Lo	cation						1	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
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39	permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Iteme 23s or 28e-f show eny injury or other treumstic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married \$ Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No		Vas Decedent I Yes, specify □ Yes 2☐		spanic Origin? (Sin, Mexican, Puerti Specify:	pecify Yes Rican, et	or No- c.)	14. Race Black,	White,	
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760.	bu icie	<u>e</u>	resulting in death) Last	Due to (or as	a conseque	nce of):								
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/ital	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Line itali				0#	26. Place of Dea	th (Check	only one)			
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× 15	To the Hospitel or Attended within 24 hours after deat To the Eunerel Directors completely filled in by the	Certification:	4 Homicide determined	building, e	tc. (Specify)					City	or Town, S	tate)		al Route Number,
	he Hosp n 24 hou ne Funel	Medical	29a. Certifier (Check only one)  1 ☐ Certifying P 2 ☐ Medical Exa	hysicien: To the best miner: On the basis o and manner si	of examinatio	ledge, death on and/or in	occurred at t vestigation, in	my op	ne, date and place pinion, death occu	, and due t rred at the	o the caus time, date	e(s) and mani and place, an	ner as s d due to	tated. the cause(s)
	To the within To the comp	M	29b. Signature and title of cartifier.						555		29d.	Date signed	Month.	
	NI		30. Name and address of person who	completed cause of	death (Item 2	23a) (Type,	Print)					1 . //		3
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	Sta Registr		555 m n 1 -	1004	aara argmatu	4								

	Registrar  1. Decedent's Name (First, Middle, L.	aetl	Ce	rtificate of	Dealli	2. Date of Deat	g. No. 2 (		29
Physician	Elise Sinton Zer					Month March	Day	Year 3. Time of 5:30	or Death ) A M
/Medical Examiner	4a. Facility Name (If not institution, gi Pickersgill	ve street and number)		4b. City, Town, o	r Location of Death TOWSON		4c. County Balt:	of Death	
Funeral Director	214-22-2076	Sex 7. Age (In )	yrs. last birthday, 100 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 2,	Year) 1904	9. Birthplace (State Country) MD	or Foreig
MO	Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town or L	ocation				10d. Inside C	City Limit
other than "natural", or Itema 23a or 28a-1 show yent, the Medical Examiner must be notified at ie Completed by Funeral Director	MD Baltim	ore	Towson					1 ☐ Yes	s 2 N
niner must be notified	10e. Street and Number 615 Chestnut Ave			10f. Zip Code 2 1 2 0 4		10	_	What Country?	
eral	11. Marital Status	12. Was Decedent Ever	in U.S.   13.		dispanic Origin? (Spe	city Yes or No-		States	
	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	Rićan, etc.)	Specify	White, etc.	
eted	15. Decedent's I (Specify only highest g		16a. Dece	dent's Usual Occup	pation during most of workii d)	ng		usiness/Industry	
Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		ol Teache			Educat	lon	
other traumatic event, I	17. Father's Name (First, Middle, Las Albert Baum	t)			18. Mother's Name Effie S		Maiden Suman	ne)	
гаита	19a. Informant's Name/Relationship				and Number or Rura				
thert	DR. William A. :			and a second particular and a	Woods Ct.	-		City or Town, State	
y or o	1 Burial 2 Cremation 3			osition (Name of matory or other place ake Crema		Mar 23		ille, MD	
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2 2	Part II. Other significant conditions	contributing to death but not	t resulting in the t	underlying cause giv	en in Part I.	23e. Did tob	1/	ribute to the cause of	
. page 2 should l						24a. Was ar autops perform 1 Yes 2	/	Were autopsy findings prior to completion of death?	availab cause of
director, pag	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 ☐ ER/Outpatie	nt 3□ DOA Oth	26. Place of Death er: 4 Wursing Hor			(0%)	
funeral c	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c. Injur Wor	y at 2	28d. Describe ho			
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To the Funeral Director: completely filled in by the Medical Certificat	29a. Certifier 1 Certifying F (Check only one) 1 Medicel Ext	Physician: To the best of my aminer: On the basis of examiner stated.	knowledge, dea mination and/or in	th occurred at the time extigation, in my o	me, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and ma ite and place,	inner as stated. and due to the cause(	(s)
N Combine	29b. Signature and title of certifier	Sala	W	29c. Licens	9 1433			(Month, Day, Year) 23, 200 MO 2	4
	1,000	V V V / /			,			/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004

State of Maryland / Department of Health and Mental Hygiene 2004

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004

Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** PM teburar 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Buttinore it Under 24 Hrs. 8. Date of Birth (Month, Day, Year Feb. 20, 1 Hopkins n/a HOSPITA 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 2□ F 213-58-1806 51 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other then "natural", or Items 23a or 28a-f ehow vent, the Medical Examinar must be notified at 1 ★ es 2 No Directo Marvland n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2400 Southern Avenue 21214 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 IX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer 11 Landscaping Co. yrs. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event, 900.8: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles R. Becker G. Stinebaugh Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ronald P. Becker/Brother 2400 Southern Avenue Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. Feb. 12, 2004 Towson, Maryland 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road Baltimore, MD Leonard J. Ruck, Inc. 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 990U /Medical Due to (or as a consequence of): Examiner MEEK ulminant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Week ONE Due to (or as a consequence of) Physician/Medical 006 week WAP ROVED BY MEDICAL EXAMINER IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hemorrhage 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 No 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes ZNo Hospital: 1 patient 2 ER/Outpatient 3 DOA 2 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Ingested tylenol and alcohol 1 ☐ Yes 2 No January 22,2004 2 XAccident Unknown 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Unknown Unknown Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Sisheel

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31. Date filed (Month, Day, Year) MAR 2 3 2004

DHMH 17 Rev 1/2001

the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

attending physician and for use as the buriaf-transit

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After t funera

Director:

within 24 hours a
To the Funerel C
completely filled To the Hospitel

death.

Baltimore, Maryland 21215-0036

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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th wolfe Street

DHMH 17 Rev 1/2001

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		For State	State of Many	•	artment of r rtificate of			No. 2004	00201
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/Medic Examin		4e. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death		4c. County of Deeth	
LAdmin		8537 LUCERNE ROAD			RANDALI	LSTOWN	;	BALTIMO	RE
Funeral		Social Security Number     6. Sex	7. Age (li	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth	plece (State or Foreign ntry)
Director		216-56-835/	51	Yrs.		Decem	ber 29,	1952   Mary	land
and	ŀ	Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
Mary -f she	to	Maryland Baltimore	e		Randa1	lstown			1 ☐ Yes 2 No
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th witl	by Funeral Director	8537 Lucerne Road				21133	U:	nited Stat	es
r dea	Iner	11. Marital Status	<ol><li>Was Decedent Eve Armed Forces?</li></ol>	r in U.S. 13.	Was Decedent of I	Hispanic Origin? (Spectan, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
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21215-0036  Id within 72 hours after death with the Maryland signer.  or than "naturel", or freme 23e or 28e-f show or than "naturel", or freme 24e or 28e-f show in the Medical Examinar must be notified at	ed b	15. Decedent's Educ		16a. Dece	dent's Usual Occu	pation	16	b. Kind of Business/Ir	ndustry
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212 d with	Completed	Elementary/Secondary (S-12)	7	Denta	1 Hygien	ist	a	nd Gross	
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yla buld to Ment Ment Ment Ment Ment Ment Ment Ment	٥	Peter Paul Brennis				Ann Rose			
Baltimore, Maryland 21215-0036  sermit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens.  Separtment of Health and Mental Hygiens, or theme 23e or 28e-1 show moy injury or other traumatic event, the Medical Examinar must be notified at 200s.	1	19a. Informant's Name/Relationship (Type Charles R. Mulligan				t and Number or Rural Road, Rand		-	
Baltimore, Ma permit. Pages 1 and 2 Department of Health a Important: If them 27 it any injury or other tra once.		20a. Method of Disposition		20b. Place of Dispo	osition (Name of	. Da		c. Location - City or T	
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altir nit. P artme ortan injur	1 9	21. Signature of Funeral Service Licerise				ess of Facility <b>Lori</b>			
Ball permit Depart Impoor		Joseph & Kol	Quer Moo.	333 8	728 Libe	rty Rd., R	andallst	own, MD 21	133-4784
<b>1000</b>		23a. Parti. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the	e death. Do not en	ter the mode of dyi	ing, such as cardiac or	respiratory arrest		Approximate Interval Between
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On O	lon:	27 Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Y		Wo	iryat 2 ork?	Bd. Describe how	injury occurred	neck again
Vision Attending or death. ector: After	icat	2 Accident investigation 3 Suicide 6 Could not be	3 -23 - 0 4 28e. Place of Injury	- At home farm st	1	_	8f. Location (Street		
Div A after Direct Dire	Certification:	4 Homicide determined	building, etc. (	Specify)	home		City or Town, S	town h	uceme Rd
Division To the Hospitel or Attent within 24 hours after dealt To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Phys	sicien: To the best of n	ny knowledge, dear	th occurred at the t	ime, date and place, a	nd due to the caus	se(s) and manner as	stated.
in 24 in 24 in pletely	edical	one) 11	ner: On the basis of ex and manner stated	amination and/or in d.					
To t To t	Σ	29b. Signature and title of certifier				se number		. Date signed (Month,	
		I highi.				C.M.E.	MAF	RCH 24,200	4
15		30. Name and address of person who co	impleted cause of deat			Street, Ba	altimore	Marvland	21201
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's		TIT LCIUI	Diffect, D	AL CHINES,	THILYTON	CILVI
Regist		MAR 2 5 2004	Selwa	4	a'	*			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 09302 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** GEORGE EDWARD BREWER, SR. 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BAHMORE KOSEGAIE MANKIN SOUBLE If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Days 1 GM 2 ☐ F 218-32-3130 Director 9/17/1931 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event. It's Medical Examiner must be notified at BALTIMORE UPPER FALLS 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 11630 FRANKLINVILLE ROAD 21156 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: Specify: Completed by 3 ☐ Widowed 4 X Divorced WHITE "natural". 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIPMENT OPERATOR ROAD CONSTRUCTION 8TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental F JOSEPH ARTHUR BREWER ANNA MARIE WILLIS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE E. BREWER, JR. SON 304 BLACKBIRD COURT EDGEWOOD. MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ō <u>=</u> 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Department of Important: If any injury or once. METRO CREMATORY, INC. 3/24/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) CATONSVILLE, MD 21. Signature Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Adeno CARCINAMA of **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner transit requires that the death certificate be executed COURENT 0101 resulting in death) Last Due to (or as a consequence of): burial-1 Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy õ in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. E ☐Yas 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I., 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, Bleed 2 000 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? extension s certificate has l lirector, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 **X**No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Apatient Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifies by basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) hanner stated.

State Registrar 29b. Signature and little of certifier

31. Date filed May Apry, 2eas

30. Name and add

FRANKLIN

ss of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

RACIMOS

29c. License number

SQUARE

29d. Date signed (Month, Dey, Year)

Wesley Boulw Unknown 04-0 04-01907	
	1- Si
Physician	1. Dec

4-(	01907		riease	• •		of Health and I	-	iono	
rn			1_ For State	State of Maryland /	•	or nealth and i e of Death		•g. No 2004	00303
			Registrar  1. Decedent's Name (First, Middle, Last	()	Certificate	or Death	2. Date of Dea		3. Time of Death
	Physici	an	MEGITY	,	Balle	WARE	Month	Day Year 17 20	04 9:21 A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		Town, or Location of Death		4c. County of De	
	Exami	E	Nursery Road at Fa		Rayn	or Heights		Anne Aru	ndel
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last			8. Date of Birth (Month, Day	Year) 9. Bi	rthptace (State or Foreign
	Director		011-14-6735	M 20F 33	Yrs.	July Hours	OCT. 15	3.1970 M	ARYLAND
	pur *		Usuat Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location			J	10d. Inside City Limits
	Aaryli Febo	ō	Aana	10	8	n : TIMAR	EAL	71/	1 X Yes 2 No
	28a-	Director	10e. Street and Number	11	10f. Zip	Code		0g. Citizen of What C	Country?
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	deeth	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		lent of Hispanic Origin? (S ify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Arr Black, Wh	
9	or Ite	F	1 Never Married 2 Married	1 □ Yes 2 No	1 □ Yes 2		0 1 110211, 010.)	Specify: (2	1 0 0 1/
21215-0036	within 72 hours after deeth with the Maryland ane. then 'naturel', or Iteme 23e or 28e-f ehow he M. olicel Exemiter mail be notified at	d by	3 Widowed 4 Divorced	Year or Dates:				70	LACK
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	filed with Hygiene. other the		17. Father's Name (First, Middle, Last)				ne (First, Middle,	Maiden Sumame)	4
lan	Mental Mental arked c	To Be	TAMES	BOUL	WARE	BER	TINA	BRO	WN
Maryland	S E E		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Address	(Street and Number or Ru	ıral Route Numbe	, City or Town, State,	Zip Code)
-	and 2 ealth a n 27 to		JAMES BOULWA	TRE (FATHER) C	222 13	OLIVAR A	VE.BA	LTO, MI	0.2/225
ore	of He		20a. Method of Disposition 1⊠Bunal 2 ☐ Cremation 3 ☐	come	e of Disposition (Nametery, crematory or of	ne of ther place)	Date	20c. Location - City o	r Town, State
Baltimore,	Pa ant ury		*4 □ Donation 5 □ Other (Specify,		ZIONCE	METERY 03-0	25-04	LANSDOWA	E, MARYLAND
3all	permit. Departr Imports eny inj		21. Signature of Funeral Service Lipens	100	22 Name and	d Address of Facility	ROWN	JR. FUNE	ERAL HOME
	<b>2</b> □ <b>5</b> • <b>0</b>		23a. Part1. Enter the disease, or comp	1. Willama	2/40	ON, FULTO	IN AVE.	BALIO.	MD: 2/2// Approximate
			shock, or heart failure. List only of	one cause on each line.	,		or respiratory an	651,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Multiple				·	
	Examiner			Due to (or as a consequent	ice of):				
1.4	44.	-e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequent	ce of):				
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C					
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3760	9 5	ical		d					
.89	artifica ing ph	Med	IF FEMALE:						
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea	ath 3 Ectopic pro			23d. Date of di Month	elivery Day Year
	requires that the death certifical een signed by the attending phy hould be detached for use as th	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	h 5 ☐ Other (sp	өспу)			
P.0.	that the by detact	Ph	Part II. Other significant conditions co	ontributing to death but not resulting	ng in the underlying ca	ause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	uires sign ld be	d by					1 🗆 Y	es 2 X No 3 □ F	Probably 4 Unknown
00	w req	Completed					24a. Was a	ın 24b. Were a	autopsy findings available
Re	The law te has b	шc					autops	med? death?	
ta	sician: The law certificate has b irector, page 2 s	Be Co	25. Was case referred to medical			26. Place of Dea	1 Yes ath (Check only or	1 . /	s 2 No
Division of Vital	ystci is cer direct	ToB	examiner? 17 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	/Outpatient 3 □ DO	O#			ecity) at scene
0	ng Ph ter th		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28	b. Time of 2	8c. Injury at Work?	28d. Describe h	ow injury occurred to bicycle th	ex collided
Sio	endir sath. or: Al he fu	atic	2 Accident investigation		=18 A M	1 ☐ Yes 2 10 No	work	a motor V.	chille
Σ̈́	or Att	Ę	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	a, farm, street, factory	r, office	28f. Location (S City or Town	treet and Number or F	Aural Route Number, y Rd at Fairvieu
	urs al urs al arel D	Medical Certification;	20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	I i i i i i i i i i i i i i i i i i i i	Koad		AVE. R	aynor Heigh	to MD
	Hos 24 ho Func stely f	dica	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exam	ysician: To the best of my knowled iner: On the basis of examination and manner stated.	and/or investigation,	at the time, date and place in my opinion, death occu	rred at the time, d	ause(s) and manner a late and place, and du	ie to the cause(s)
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier		290	. License number	2	9d. Date signed (Mor	nth, Day, Year)
	P > P 0		> Lin his	m.D		O.C.M.E	Ξ.	March 18,	2004
-	7		30. Name and address of person who o	completed cause of death (Item 23	3a) (Type, Print)				
	V			mid	111 Pe	enn Street, E	Baltimore	, Maryland	1 21201
85	Sta		31. Date filed (Month, Day, Year) MAR 2 5 20	32 Registrar's Signature					
	Regist	rar	MHU & 9 50	04 Brown St.	( Soule				

DHMH 17 Rev 1/2001

			For State Registrar	State o	of Marylan		artment of H rtificate of		Mental Hyg	jiene 100. No 200	4 09304
			1. Decedent's Name (First, Midd	e, Last)					2. Date of Dea Month	Day Yea	3. Time of Death
	Physici /Medic		Charles F. B	enton, Jr					MARCH	23, 2004	3:19 P M
	Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, o	Location of Death	1	4c. County of De	ath
			JOHNS HOPKINS	HOSPITAL			BALTIMO	RE CITY			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	( Year) 9. E	Birthplace (State or Foreign Country)
	Director		218-28-9408	1 🛣 M 2 🗆 F	69	Yrs.	Months Days	Tiodis iviii.	(Month, Day Aug. 21	,1934	MD
	P _		Usual Residence of Decedent		140.00	T					104 1-14-05-11-14
	thow thow		10a. State 10b. County		10c. City	r, Town or Lo	cation				10d. Inside City Limits
	Ba-f.	cto	MD Ba	ltimore		Reis	sterstown				1 Yes 2 No
	11. th	Oire	10e. Street and Number				10f. Zip Code		1	10g. Citizen of What	Country?
	23a	Funeral Director	600 Sungold				2113			USA	
	e mas	aur.	11. Marital Status	Armed F		S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, Wi	merican Indian, hite, etc.
36	or II	YF	1 ☐ Never Married 2 ☑ Mai	ned 1 X Yes If Yes, G	2 □ No ive		1 ☐ Yes 2 ☑ No	Specify:		Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show tha Madical Examirer must be nutified at	d by	3 Widowed 4 Divorce		Dates:	100 Dage	dent's Usual Occup	atron		10h Kind of Busines	White
5	"nat	Completed		nt's Education est grade completed	)	(Give	kind of work done  DO NOT use retired	during most of wor	king	16b. Kind of Busines	ss/moustry
12	Mithir Shan	Ę.	Elementary/Secondary (0-12) 1 2	College	(1-4or 5+)		er Electr			Electri	ical
	Hygie Hygie Sther ant, II		17. Father's Name (First, Middle	Last)		Maste	er Erectr		ne (First, Middle,	Maiden Sumame)	ICAL
Maryland	buld be filed with Mental Hygiene arked other that atic event, the	Be	Charles F. Be					Doroth	y Mae Co	ok	
Ž	should and Men marke	2	19a. Informant's Name/Relation			19h Marlin	na Address (Street			r, City or Town, State	. Zip Code)
Ma	d 2 sho h and l 7 is me traume		Constance C. B		Wife		Sungold		stown, M		,, _,, _,,
	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Madical Examinat mast to nullitied at		20a. Method of Disposition	encon	20b. P	lace of Dispo	sition (Name of		Date	20c. Location - City	or Town, State
٥	Pages nent of int: If It		1 🔀 Burial 2 □ Cremation		State C	emetery, crei	matory or other plac		101	Sykesville	
Baltimore,	rtmer rtant		' 4 □ Donation 5 □ Other (3		Lak		Mem. Par			-	
Bal	permit. Pages 1 and: Department of Health Important: If Item 27 any injury or other tr <u>once</u> .		21. Signature of Chiefral Softwice					•		Reistersto	
	20244		23a. Part 1. Enter the disease, of	Policewo	<i></i>		line Fune			rstown, MI	Approximate
1.	Physician /Medical Examiner business and business the prival-transit the prival-transit	Examiner	disease or condition resulting in death)  Security list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	o (or as a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a consequence of (or a c	uence of): uence of):	losclerot	ic Cardi	ovascula	r Disease	
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687	phys phys s the	dicai		d							
O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregna birth 2 Fetal gnant at time of de nown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of o	delivery Day Year
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rds	quire in sig uld b	pa							1 □ Y	es 2□No 3□	Probably 4 Unknown
Il Records,	The law ate has b page 2 st	Completed by							24a. Was a autop: perfor 1 Yes	sy prior t med? death	autopsy findings available to completion of cause of ? es 2 \( \text{No} \)
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?				0.4	05	th Check only or	771	
Name .	ys dis	2	1 X Yes 2 □ No		- N. M.	R/Outpatier		4   Nursing F		ence 6 Other (S)	pecify)
L C	Ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pend	ng 28a. Date (Mo	of Injury onth, Day Year)	28b. Time o Injury	Wor		28d. Describe h	ow injury occurred	
Sio	eath.	cati	2 Accident invest	igation not be				Yes 2 □ No	206 1 10 10		0 -10 10
Division of	or At fter d lirect n by	Certification:		nined 286. Plac	ding, etc. (Specif)		reet, factory, office		City or Tow	n, State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medica	I Examiner: On the	basis of examina					ause(s) and manner late and place, and d	
	the the	Medical	29b. Signature and title of certifit		nner stated.		29c. Licens	e number		29d. Date signed (Mo	onth. Dav. Year)
	5 <u>5 5</u> 6			i mid					-		
	\			· .				CME		MARCH 24	±, 2004
_	dx,		30. Name and address of person	, mid				nn Stree	t, Balti	more, Mary	yland 21201
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea.	2	Registrar's Signa		and I				

			riease	State of Marylan					
			1 - For State Registrar	State of Marylan		ficate of Death	ia montai in	Reg. No. 200	4 09305
			Decedent's Name (First, Middle, Last				2. Date of D Month	eath Day Year	3. Time of Death
	Physici /Medic		Katherine	B. BURCH			3	23 04	3:00A.M
	Examin		4a. Fecility Name (If not institution, give		41	b. City, Town, or Location of I	Death	4c. County of Dea	
			5. Social Security Number 6. Se	7. Age (In yrs. i		Under 1 Year If Under 24		irth 9. Bi	MORE rthplace (State or Foreign
ı	Funeral Director		219-38-4790 1	JM 2/15 9	Yrs. M	lonths Days Hours	Min. (Month D	1910 M	aryland.
	pu .		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Locat	ion			10d. Inside City Limits
	Aaryla f sho	៦	m	noRE	Mont				1 ☐ Yes 2 No
	r 28a-	rect	10e. Street and Number	2		10f. Zip Code		10g. Citizen of What C	Country?
	th with	a D	18210 Corbett	Rd.		21111		USF	7
	er dea	Funeral Director	11. Maritaf Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was	s Decedent of Hispanic Origin es, specify Cuban, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	14. Race - Am Black, Wh	
36	urs aft		1 Never Married 2 Married 3 1 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 🗆	Yes 20 No Specify:		Specify: U	hite.
21215-0036	s within 72 hours after death with the Maryland liene. r than "natural", or itama 23a or 28a-f show Itta Mooreal Examiner must be notified at	Completed by	15. Decedent's Edu (Specify only highest grad		16a. Deceden	t's Usual Occupation	of working	16b. Kind of Busines	s/Industry
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lan	od la b	To Be	George Ba	usch.		Ros	se Hir	nmer.	
Maryland	d 2 should th and Men 7 is marke traumatic		19a. Informant's N. me/Relationship (T.	rpe, Print)	19b. Mailing A	Address (Street and Number	or Rural Route Num	ber, City or Town, State,	Zip Code)
_	s 1 and 2 f Health item 27 other tr		Jeanne Cole	-claughter	Place of Disposition	Corbette	1. Monk	20c. Location - City o	Town State
Jore	S == = 0		20a. Method of Disposition  1	Removal from State	cemetery, cremat	ory or other place)	115 7.7/	ri mora	^
Baltimore	를 된 <b>보</b> 등 .		* 4 ☐ Donation 5 ☐ Other (Specify)		Ceney Val	ley Men Critate am and Address of Facility	2375 VAP	VRA TIMOUI	UMMD CTR
Ba	permit. Depart Import any inj		Kimber Cer ().	Bullotan	PEA	CEPULALTERI	NATIVESF	FUNERAL+C	
			23a. Part1. Enter the dise , or comp shock, or heart failure. Vist only of	ications that caused the death	h. Do not enter t	he mode of dying, such as ca	ardiac or respiratory	arrest,	Approximate 2/0 L Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition			R ACCIDENT			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	juence of):				
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760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a conseq	juence of):				
687	leath certificate t attending physic of or use as the b	dical		d					
Box (	nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of de	elivery
_	death	sicla	in the past 12 months?	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		topic pregnancy ther (specify)		Month	Day Year
P.O.	that the de led by the a detached f	Physician/Medi	9 Unknown  Part II. Other significant conditions co		sulting in the unde	artying cause given in Part I	23e. Did	tobacco use contribute	to the cause of death?
	signed by det	þ	Pattii, Other signmeant conditions of	TRADULING TO COULT DUT HOT 105	adding in the drive	mying oddoo gwori ii r dara			Probably 4 Unknown
cor	w require been si should	Completed					24a. Wa		autopsy findings available
Re	The lay	ошр					aut per 1 ☐ Yes	formed? death?	completion of cause of
ita		BeC	25. Was case referred to medical examiner?		-		of Death (Check only		
of Vital Records,	Physician: this certifican ral director.	မ	1 ☐ Yes 2 🗹 No					sidence 6 Other (Sp	ecify)
on (	ding F h. After funer	tlon	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		how injury occurred	
Division	Atten r deat ector: by the	ifica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of fnjury - At he building, etc. (Specif		, factory, office		(Street and Number or Foundary )	Rural Route Number,
Ö	tal or	Certification:	4   Nothicide	building, etc. (Specin			ony or .		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 ☑ Certifying Phy (Check only 2 ☐ Medicel Exam	rsician: To the best of my kno iner: On the basis of examina	owledge, death or ation and/or inves	ccurred at the time, date and stigation, in my opinion, death	place, and due to the concurred at the time	e cause(s) and manner a e, date and place, and du	as stated. ue to the cause(s)
	othe ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mor	
	->-0		· imjanso.	we ND		D16619	7	March.	23, 200cf
	7		30. Name and address of person who	ompleted cause of death (fter	m 23a) (Type, Pri	nt) ARY AVE. L	MALED:	Ir Mo s.	00:2
	<u> </u>	210	C.VERGARA - SOF 31. Date filed (Month, Day, Year)	32 Registrar's Signa		ARY AVE.	MINEKVIL	t, 100. 2/	093
	Regist	ate rar	MAR 2 5 200	6	1 Aven	W			

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ORIGINAL

COCKE ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200 i 09307 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 12:30 Am llam. 2004 /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) 4c. Examiner MARYLAND MUSONIC Homes

5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday) Keysuille Baltimore if Under 24 Hrs. 8. Date of Birth (Month, Day Year) 6. Sex. 1 M M 2 □ F If Under 1 Year Birthplace (State or Foreign Country) Funeral Months 204-05-33 Days 32 Director Pennsylvania Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c, City. Town or Location r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2√☐ No MD Baltimore Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9501 Powderhorn Lane 21234 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: white Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill thent of Health and Mental Heart: If item 27 is marked oth jury or other traumatic even Be William Howard Bailey ဂ Carrie Etta Kohler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9501 Powderhorn Lane Baltimore, MD Florine Bailey/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signiture of Euneral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Chour destrutue Permoney Disase Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed nding physician end use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha cause of death? 3 Probably 4 □ Unknown 1 X Yas 2 □ No Completed by should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has funeral director, page 2 1 Tes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours e Medical 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)
MAR 2 5 2004

LIBGATO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NUS

35D & BAWK 5T 2. Registrar's Signature

Beelte,

KOBERT

		4	For State Registrar	State of Maryland			r Health and N of Death	nentai Hyg R	eg. No. 200	4 09308
			Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h	3. Time of Death
	Physicia		LINDA S.	BINGHAM				3	Day Yes	
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Tow	n, or Location of Death		4c. County of D	eath
		•	UNIV MARYLA	NO MED. S	YSTEM	BALT	IMORE			N/A
- 3	Funeral		Social Security Number     6. Sex	7. Age (In yrs. Is		If Under 1 Ye Months Da		8. Date of Birth Month, Day JUNE 14	Year) 9.1	Birthplace (State or Foreign Country)
	Director		211-38-6162	M 207 64	Yrs.			JUNE 14	4,1939	MD
	pu 🗼	}	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loca	ation				10d. Inside City Limits
	ehov	5	MD N/A		BALT					1 ☐ Yes 2 ☐ No
	Ne N	Director	10e. Street and Number		DALI.	10f, Zip Cod		1	0g. Citizen of What	Country?
	with a	급	1103 W. HAMBURG S	TREET			21230			U.S.A.
	within 72 hours after death with the Maryland ene. Itan "natural", or tleme 23e or 28e-f ehow the Madical Examinar must be notified at	Funeral		2. Was Decedent Ever in U.	S. 13. W	as Decedent	of Hispanic Origin? (Sp	pecify Yes or No-		merican Indian,
_	ter d	P.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	lf.	Yes, specify (	Cuban, Mexican, Puerto	Rican, etc.)	Black, W	/hite, etc.
25	lrs al	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	11	□Yes 2127	No Specify:		Specify:	WHITE
Ş	2 hou	ted	15. Decedent's Educ		16a. Decede	ent's Usual Oc	ccupation one during most of work	kina	16b. Kind of Busine	ss/Industry
בוב	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use re		9		
7	d wit	Completed		2	OWNE	₹			CLOTHING	
<u> </u>	be filed tal Hygi of other event, I	Be (	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
<u>a</u>	s I and 2 should be filed within 72 hours after death with the Marylan Health and Mental hyghen. Health and Mental hyghen witem 27 is marked other than "natural", or liteme 23s or 28s-1 show item 27 is marked other than "natural", or liteme 23s or 28s-1 show item 27s or 18s in a Maryland Examinat must be inclined at	2	ALBERT		KASO		BEATRI			TUERK
an L	2 sho		19a. Informant's Name/Relationship (Type				reet and Number or Ru			
≥	es 1 and 2 of Health of litem 27 li r other tra		RALPH I. BINGHAM			-	MBURG STREI		I I MURE M 20c. Location - City	
ore e	of Hi		20a. Method of Disposition 1	emoval from State	lace of Dispos emetery, crem	atory or other	place)	1		
Ĕ	Pag ment ant: I		*4 □ Donation 5 □ Other (Specify)	HEB			N CEM. 3/23		WOODLAW	
Baltimore, Maryland 21215-0036	permit. Pages 'Department of Inportant: If ite any injury or of once.		21. Signature of Funeral Service Lice	P. Contraction of the Contractio					SON & BRO	
	20239		- Jano				ISTERSTOWN	-		E, MD 21208 Approximate
-			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each line.	n. Do not ente	r the mode of	dying, such as cardiac	or respiratory arr	<b>es</b> t,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or conditiona	END SIA	E L	VER E	ASEASE,	CIRRHA	515	4
	/Medical Examiner		resulting in death)	Due to (or as a consequent	uence of):					
	Examiner	١. ا	Sequentially list conditions, b	Due to (or as a consequence	Ą					
	p ti	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury		derice oi).					
	and tran	Karr	that initiated events cresulting in death) Last	SEPS S  Due to (or as a conseq	uence of):					
80,	De ex	E		550 (5) (5) 25 5 5 5 5 5						
8760,	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	_ d	l						
9 ×	leath certific attending p	Physician/Me	IF FEMALE: 2	3c. If yes, outcome of pregna	incy				23d. Date of	delivery
Box	atten for us	ian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3 🗌	Ectopic pregr Other (specif			Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		( <b>-</b>	//			
<u>α</u>	that the de led by the a detached t		Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	derlying caus	e given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
ds,	sign d be	d b	ASTHAA					1 🗆 Y	es 2□No 3□	Probably 4 Unknown
of Vital Records,	w requir been si should	Completed by						24a. Was	an 24b. Wer	e autopsy findings available to completion of cause of
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<u>=</u>	icien: Th certificate ector, pag						OC Place of Day	1 ☐ Yes		Yes 2□No
ξ	Physicien: rthis certifica ral director.	Be	25. Was case referred to medical examiner?	lospital:	ER/Outpatient	3□ DOA	Other		lence 6 ⊟Other (	Speciful
to	Phys this ral di	2	1 Yes 2 No	28a. Date of Injury	28b. Time of		Injury at Work?		ow injury occurred	эрөску)
O	ding h. After fune	io	1 ☑Natural 5 ☐ Pending	(Month, Day Yeer)	Injury	м	Work? 1 ☐ Yes 2 ☐ No			
Division	l or Attending after death. Director: After	lica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, stre	et, factory, o	ffice			r Rural Route Number,
S	after Dire	Certification:	4 Homicide	building, etc. (Special	(y)			City or Tow	m, State)	
	he Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge, death	occurred at 1	the time, date and place	and due to the	cause(s) and manne	er as stated.
	P Ho 1 24 h 1 Fu lefei)	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ition and/or inv	estigation, in	my opinion, death occi	irred at the time, o	date and place, and	due to the cause(s)
	within 2 To the	M	29b. Signature and title of certifier			29c. L	icense number		29d. Date signed (A	
			1 / 5 Moon	M.D.		/	21768		3-20-	G <del>1</del>
	'n		30. Name and address of person who co	ompleted cause of death (Iter	п 23а) (Туре,					
	.,		GEUFFRET	MOURER	22	2 5.6	REENE S	ST G	3AZTIMORE	MD 21202
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					

State of Maryland / Department of Health and Mental Hygiene 2004 09309 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 6.55 Pm MARCH Ame 5 2004 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Locetion of Deeth 4c. County of Deeth Examiner BALTIMURE Medical BALTIMURE if Under 1 Year if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 → M 2 □ F Yrs 217-14-4266 Director 81 Aug. 17,1922 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Heath and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evarings mans be notified as 10a, State 10b. County 10c. City, Town or Location I is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland Baltimore Dundalk 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7448 Durwood Road 21222 United States 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. StYes 2 ☐ No Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Completed by Specify. 3 Widowed 4 Divorced White Year or Dates: WWIT 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Tire Mechanic General Rubber Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Carr Linnie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Sharon L. Riedel / Daughter 542 Pembrooke Court Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. 3/22/2004 Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Irc. 7922 Wise Ave. Dundalk, Maryland art1. Enter the during, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear mure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed attending physician end for use es the bunel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. by Physician/Medical Due to (or as a consequence of) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy **10**S certificete 21. No 1-dr Yas 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ဥ 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Director: After thid in by the funeral 28b. Time of Injury 27. Menner of Death . Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth. 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide within 24 hours aft To the Funeral DI completely filled in † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P17658 9/04 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 10 N GREENE Street BALFinale, MS 21201 KRISTINA MANKES MD 31. Date filed (Month, Day, Yeer) 32 Registrer's Signature State MAR 2 5 2004 Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Maryland / De	epartment of Health and M Dertificate of Death	lental Hygien	Z11115 HUZ11
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last  A i L D A  4a. Facility Name (If not institution, give	.M. Cook	4b. City, Town, or Location of Death	1.1-1161	Yeer 3. Time of Death 2. Co. A. M.
	Examir Funeral Director	ier	5. Social Security Number 6. Se 213-36-3262	eg Knoll CT.	COCKEYS VILLE  Tay) If Under 1 Year   Hours   Min.	8. Date of Birth (Month, Day, Year 7 e.b. 26,19	BALT, MORL  9. Birthplace (State or Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Evarigher must be routified at once.	To Be Completed by Funeral Director	Usuel Residence of Decedent  10a. State  10b. County  BALT  10e. Street and Number  S_C. OUTM  11. Marital Status  1 Never Married Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade (Specify only hig	Part of the state	10f. Zip Code  2 10 30  13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto of the Yes of Specify:  1 Yes 2 No Specify:  ecedent's Usual Occupation Give kind of work done during most of working. DO NOT use retired)  CASHIER  18. Mother's Name  5 Tell (American Companion (Name of Crematory or other place)	necify Yes or No-Rican, etc.)  16b. h  (First, Middle, Maider  1 Beel  1 Route Number, City  1 ate 20c. L	or Town, State, Zip Code)  (x M) 2/13/ ocation - City or Town, State
8760,	Any sicien and hysicien and hysicien and hysicien and the burial-transit	al Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)  Due to (or as a consequence of)  Due to (or as a consequence of)	tenter the mode of dying, such as cardiac o		Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
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Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowledge, oner: On the basis of examination and/of and manner stated.	death occurred at the time, date and place, a pr investigation, in my opinion, death occurre	and due to the cause(s ad at the time, date and	) and manner as stated. d place, and due to the cause(s)
	Tot withi Tot com	W	29b. Signature and title of certifier  30. Name and address of person who co		29c. License number 13 2 23 5 6  (pe, Print) Rever Range		te signed (Month, Day, Year)  Luck 22, 2004  End 21239
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Snall!	/Sa ()	2) MICH 21 63 1

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	Physici /Medic		1. Decedent's Name (First, Middle, Lasi Gene A.	o Crawford					2. Dete of Dee Month	Day	Year 04	3. Time of Deeth 07; 29 p.M.		
٩	Examir		4a. Facility Name (If not institution, give				4	4b. City, Town, or L	ocation of Death	4c. County	of Death	ORE		
	Funeral Director		212-34-7323	7. A M 2□F	ge (In yrs. le	Montr	ler 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April		9. Birthplac Country West	ce (State or Foreign Virginia		
	Maryland f show	ō	Usual Residence of Decedent  10a. State 10b. County  Maryland N	/ A	10c. City,	Town or Location	Ва	altimore				I. Inside City Limits XIXI Yes 2 □ No		
	n with the 13a or 28a at be rediff	al Direct	10e. Street and Number 4326 Evans Chapel	Road		10f. i	Zip Code	21211		10g. Citizen of \	What Country	USA		
020	urs after deatl al', or items 2 Exeminer mu	by Funer	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces XIXI Yes 2 ☐ If Yes, Give Year or Dates	No	1 U Vos		lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rad Blad Specify	ce - American ck, White, etc	o.		
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ONCE.	Completed by Funeral Director	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) unknown	ucation le com <i>pleted)</i> College (1-4or	5+) I	16a. Decedent's U (Give kind of life. DO NOT Parts Depa				16b. Kind of B				
/land	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ms	To Be C	17. Father's Name (First, Middle, Last) Fay Crawford							e (First, Middle, Maiden Sumame) na Marteney				
/ar	2 sho and ? is ma	i i	19a. Informant's Name/Relationship (T								or Town, State, Zip Code)			
Baltimore, 1	ages 1 and 3 ant of Health It: If Item 27 i y or other tr		Doris Crawford  20a. Method of Disposition  12 Dornation 3 DI 4 Donation 5 Other (Specify,			4326 Evan ace of Disposition (A metery, crematory of View Mer	lame of r other place	ce)	Date	nore, Ma 20c. Location - Sykesv:	City or Town	n, State		
Baltii	permit. Pag Department Important: I any injury o		21. Signature of Faneral Service Micens		7	22. Name Burge	and Addre	ss of Facility nss-Seitz		L Home,	Inc.			
	Physician	10 T	23a. Rart 1. Enter the disease, or comp shock, or heart failure. List only of	lic tions that cause one cause on each	ed the death. line.						A	pproximate Iterval Between Inset and Death		
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	Due to (or	temor as a consequence	n ha	re.	Thomas	of C	- 7	= lep,		
	ecuted and transit	camine	Sequentially list conditions,	b	Due to (or	as a consequence of	f):	O Cim.	Ane	my.	2m	- W.		
68760,	The law requires that the death certificete be executed at has been signed by the attending physician and page 2 should be detached for use as the buriel-transit	ledical Examiner	Sequentially list conditions, if any, feating to him. diatocause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or	as a consequence o	f):							
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s, P.O	s that the gned by t be detach	by Phy							1 🗆 Y	′es 2□No	3 Probat	bly ∮⊠¹Unknown		
Records,	law require as been si	Completed							24a. Was a perfor	an autopsy med?	availa	autopsy findings able prior to detion of ceuse ath?		
al H	ician: The law certificate has rector, page 2	S							1□ Y		1□Y	es 2 No		
Vital	Physician: this certific	To Be	25. Was case referred to medical examiner? 1 BYes 2 □ No	Hospital:	tient 2□F	ER/Outpatient 3□	DOA Oth	26. Place of Dea	th <i>(Che</i> ck only or ome 5□Reside		er (Specify)			
ion of	To the Hospital or Attanding Physician: within 24 hours efter death.  To the Funeral Director: After this certificd completely filled in by the funeral director,		27. Manner of Death 1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	iurv	28b. Time of Injury M	28c. Injur Wor		28d. Describe h					
Division	tal or Atters of selecters al Directers led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (S City or Tow	n, State)								
	To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier 1 Check only one) 2 Medical Exem	pinion, death occur	red at the time, d	date and place,	and due to th	ne cause(s)						
D	To To Con	Σ	29b. Signature and title of certifier	d'è			29c. Licens	0 6 5 3	}	Tarel	Q (Month, Da	2004		
_	10		Roser E, Same	ompleted cause of	301 0	Sper 1	nie	, Tou	ben,	Man	gara	2/204		
	St	ate	31. Date filed MAR 2 5 2004	2. Regis	trar's Signat	ure		•		(	-			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2004 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death lizabeth Month **Physician** 5:3/A 2009 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltmore **Examiner** Gilchrist Center Ό, 10W501 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 F 89 153-14-0515 Yrs Director NEW Usual Residence of Decedent with the Maryland 10a. State 10h 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23a or 28a-f show Examiner must be notified at timore (o. Glen 1 ☐ Yes 2 No Marytand Ba Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road 11630 2105 U. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forcen? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □ Yes ANO Specify: Whi Baltimore, Maryland 21215-0036 Widowed 4 □ Divorced Specify: þ "neturel" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry manufact. other then Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 14 N 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gombos and Mental Joseph Is marked Ceceila Becsei 19a. Informant's Name/Relationship (Type, Print) (Davight 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD. 21209 Versalles Circle, nt of Health a : If item 27 is E. Carrela 129F. Beverly 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) rtment of Evans Funeral (Napa. Mar. permit. Page Department Importent: If any injury o 21. Signature Funeral Service tunera/+(ren onium, MD. 2109 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List doly one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death pulmonary **Physician** OG5 Much up disease hronic 100020 /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknowe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1⊠Yes 2□No 3 Probably 4 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t irrector, page 2 s autopsy performed? ≱ No 1 ☐ Yes or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 ₺No 4 ☐ Nursing Home 5 ☐ Residence 6 POther (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After that in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours aft

To the Funerel Di

completely filled in To the Hospital 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58303 March 24 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V 6601 N. Charles St Baltimore mD 21204 Arran J. Charles MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 5 2004

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Crudele Elizabeth

		1 For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryland /	Department of Certificate of	Health and M Death	Mental Hygie Reg. 2. Date of Death	ne 2004	3. Time of Death
Physi /Med Exan	dical	Willard Carson  4a. Facility Name (If not institution, give st 12700 Bedford Ro	reet and number)		or Location of Death erland	Month March 12	Day Year 2004 4c. County of Deetl Allegany	12:45PM M
Funera Directo		5. Social Security Number  219-14-5464  Usual Residence of Decedent	7. Age (In yrs. last to 80	yrs. If Under 1 Yea Months Days		8. Date of Birth (Month, Day, Ye Mar 14,	9. Birth Con 1923 Man	nplace (State or Foreigr untry) cyland
he Maryland 28a-f ehow	ector	10a. State 10b. County MD Allegany  10e. Street and Number		berland		100	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2√ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	12700 Bedford Roa  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	d. 2. Was Decedent Ever in U.S. Armed Forces? 1 ሺYes 2 □ No If Yes, Give Year or Dates: WWII	13. Was Decedent of If Yes, specify Cu			USA  14. Race - Amer Black, White Specify: Wh:	ncan Indian, e, etc.
d within 72 hours aff giene. or than "natural", or the Medical Exami	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ition 16	ia. Decedent's Usual Occi (Give kind of work don- life. DO NOT use retir upholste	e during most of work ed)	sing 16t	Eurnitur	
nd 2 should be file Ith and Mental Hy 27 Is marked other r traumatic event.	To Be (	17. Father's Name (First, Middle, Last)	a. Print) 19	9b. Mailing Address (Stree		Mae Reed	,	in Code)
ges 1 and 2 s it of Health ar If Item 27 le or other trau		Bonnie Cook/daught  20a. Method of Disposition  1  Burial 2  Cremation 3  Re	er 20b. Place cemei	12122 Little of Disposition (Name of tery, crematory or other pl	Patuzent	Pkwy Colu		21044
permit. Pages 1 a Department of Hec Important: If Item any injury or othe	once.	21. Sign vu Funeral Service Licensee Rona I d . W.	i de la la la la la la la la la la la la la		atomy Boar	d 655 W.		Street
Physicia /Medica Examine	at	23a. Part1. Enter the disease, or combile shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Dicause on each line.  Arteriosclero  Due to (or as a consequence Diabetes	tic heart di		or respiratory arrest,		Approximate Interval Between Onset and Death UK YYS
	cai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence					
death certifica e attending ph id for use as th	by Physician/Medi		c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	th 3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of delin	very Day Year
The law requires that the disternment of the factor of the			hypertension	in the underlying cause g	iven in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
	e Completed	25. Was case referred to medical				24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available ompletion of cause of 2□ No
ding Ph After th funeral	ToB	examiner? 174 Yes 2 No		. Time of 28c. Injury	ther: 4 🗆 Nursing Ho	th (Check only one) ome 5 X Hesidence 28d. Lescribe how in		ify)
	ai Certification:		28e. Place of Injury - At home, building, etc. (Specify)	ge death occurred at the	time date and place	28f. Location (Stree City or Town, Si	e(s) and manner as	hateta
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medicai	(Check only 2) Medical Examine 29b. Signature and title of certifier	or: On the basis of examination a and manner stated.	and/or investigation, in my	opinion, death occur ase number \$157	red at the time, date	Date signed (Month, rch 12 200	to the cause(s)  Day, Year)
•	State		pleted cause of death (Item 23a Pty Med Ex 12  Registrar's Signature	(Type, Print) 4 W 3rd St	Cumberland	MD 21502		

			1 - For State Registrar	State of Maryland	Department of H Certificate of L	ealth and M Death	ental Hygier		09315
	Physici	an	1. Decedent's Name (First, Middle, Last) $SUSQV$	M		Cay	2. Date of Death	Day Year	3. Time of Death 1605 M
	/Medic Examir		4a. Facility Name (If not institution, give st	treet and number)	4b. City, Town, or	Location of Death		4c. County of Death	. :
ng d	Funeral Director		5. Social Security Number 6. Sex 301-34-2661	7. Age (In yrs. last	birthday) If Under 1 Year  Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes	ary 9. Birthp Cour	lace (State or Foreign
	Maryland -f show	lor	Usuel Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location  Marriots				0d. Inside City Limits
	with the Min or 28a-f	Director	10e. Street and Number	0.1	10f. Zip Code		10g. (	Citizen of What Cour	ntry?
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, It a Medical Exaction moust be redified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1   Yes 2 2 3 No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
Maryland 21215-0036	rithin 72 hours ne. hen "natural", e Medical Exo	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 16	6a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	luring most of workin )	ng 16b.	Kind of Business/Ind	
land 21	s 1 and 2 should be filed within 72 hc if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical	To Be Cor	17. Father's Name (First, Middle, Last)  Tomes Smi	th	Housewit	18. Mother's Name	(First, Middle, Maid		tic
	1 and 2 should I Health and Meni em 27 is marke		19a. Informant's Name/Relationship (Typ		9b. Mailing Address (Street a	and Number or Rural		y or Town, State, Zip	
Baltimore,	Page nent o snt: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	of Disposition (Name of stery, crematory or other place)	Di		Location - City or To	own, State
Baj (	permit. Departm Importa any inju		21. Signatur, Fuleral Service Lio	hand	22. Name and Addres	1933 Mig	-Valley Dr	· Jussep, P	A 18434 Approximate
	Physician /Medical		shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause pa each line.	ratory	Arre			Interval Between Onset and Death
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P.O. Box 6	ne death certific the attending p hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea  4 Pregnant at time of death 9 Unknown	ath 3 Ectopic pregnancy			23d. Date of delive Month	ry Day Year
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Vital Records,		Completed					24a. Was an autopsy performed?	prior to cor death?	osy findings available inpletion of cause of 2 No
of	ding Physician: Th n. After this certificate funeral director, pag	on; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  27. Mann		Outpatient 3 DOA  o. Time of 28c. Injury Work	at 2		6 ☐Other (Specify jury occurred	')
Division	ten deatl tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)		′es 2 □ No	8f. Location (Street: City or Town, Sta	and Number or Rura ate)	l Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Exemina	cian: To the best of my knowled er: On the basis of examination and manner stated.	ige, death occurred at the tim and/or investigation, in my op	e, date and place, ar inion, death occurre	nd due to the cause d at the time, date a	(s) and manner as str nd place, and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Et ma	29c. License	9296	3	Date signed (Month, L	Day, Year)
-	9		30. Name and address of person who con R. Ricketts	npleted cause of death (Item 23a	a) (Type, Print) LUE STMIII	nster	MID	2115	>
	Sta Registr	-	31. Date filed (Month, Day, Year)  MAR 2 5 2004	2. Registrar's Signature	forther				

			1 - For State Registrar	State of Mary		artment of F		R	leg. No. 2	2004	09316
в	Physic	ian	1. Decedent's Name (First, Middle, Last	Dwyer				2. Date of Dea Month	Day	Year	3. Time of Death  2:06 PM
	/Medi		Joseph F  4a. Fecility Name (If not institution, give	·		4b. City. Town, o	or Location of Death	March	24 4c, Ce	2004 ounty of Death	2.06 F.
	Examir	ier	university of Mas		al Center	Bultin			N	Á	
\$	Funeral Director	E=:	5. Social Security Number 6. Se 027–42–3319	x 7. Age (In	yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day AUG 3,	1952	9. Birthp Cour Mass	olece (State or Foreign otry) Sachusetts
	land bw		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ecation				1	0d. Inside City Limits
	Mary B-f sh	tor	Maryland Baltimon	re 1	Parkville	9					1 ☐ Yes 2 ☐No
	ath with the 23a or 28	Funeral Director	10e. Street and Number 1718 Wentworth Ave	enue		10f. Zip Code 21234		1	0g. Citize USA	n of What Cour	ntry?
215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28s-f show or other traumatic event, the Madical Exercities must be putilled at	b	11. Marital Status  1 □ Never Married 2 ☑ Marned  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		. Race - Americ Black, White, pecify:	
2-0	72 ho	eted	15. Decedent's Ede (Specify only highest grad		(Give	dent's Usual Occup	during most of world	king	16b. Kind	of Business/In-	dustry
121	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Realt	DO NOT use retired	d)		Real	Estate	3
d 21	filed with Hygiene. other than	Be Co	17. Father's Name (First, Middle, Last)		1.0021		18. Mother's Nam	ne (First, Middle,		-	
Maryland	Mental I Merked o arked o	To B	Francis Dwyer				Margare	et Flynn			
lan)	2 should and Men is marke	ľ	19a. Informant's Name/Relationship (T)	ype, Print)			and Number or Ru	ral Route Number	r, City or T	own, State, Zip	Code)
	1 and 1 Health tem 27 other tr		Margo Dwyer/Wife			Wentwort		Parky:			234
Baltimore,	Peges 1 nent of 1- int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I			sition (Name of matory or other place				tion - City or To	
Ë			* 4 □ Donation 5 □ Other (Specify, 21. Signature of Figneral Service Licens			ematory I				imore,	MD
Ba	permit. Departr Imports any inj	1 18	Thomas Gregor	ye		remation 99 Frede	ss of Facility Society rick Road	of MD, l Balt	Inc.	MD 2	21228
	Physician /Medical Examiner	her	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Social field in the cause of the cause. Enter Underlying Cause (Disease or injury)	a. Suptional the subset of the cause on each line.  Due to (or as a condition of the cause)  Due to (or as a condition of the cause)  Due to (or as a condition of the cause)	cemia nsequence of): V Non-						Approximate Interval Between Onset and Death
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		t 30 Och Oth	00	th (Check only on	-		
of	ding Phys h. Alter this funeral di	1; To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of	1 JU DOX	4 🗆 Hursing no	ome 5 Reside			")
ion	nding ath. r: Alte e fune	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury		k? Yes 2 □No		,,		
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Alter completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stropecify)	eet, factory, office		28f. Location (St City or Town		lumber or Rura	l Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying Phy cone) 2 Medical Exami	sician: To the best of my iner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) an ate and pla	d manner as sta ace, and due to	ated. the cause(s)
	with To t	Σ	29b. Signature and title of certifier	2 mp		29c. Licens				igned (Month, L	•
	n		Shristan 2 c	Ju-			164357144			h 24,	
	9		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type, Ity of Max	yland Med	dical Cent	er 22 S	outh	Greens timore N	Street 2120
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	signature						

State of Maryland Department of Seath and Mental Hydrogene 0.01 4. 09.31 7    Private    Physician  Microsol  Martin Land Discharge  M	ATRI	CIA DAV	/IS	For Unpend Ttem#23a	State of Maryland / Dep Part TI 27 289-f Per Mr.	artment of Health and	Mental Hygie	ne nol.	00217	
Physician March and Suppose State of American Indian Indi	Physician   Phys				* Hegistrar		rtificate of Death	Heg.	No.C U U 4	3 Time of Death
4. Chy, Town or support year or residency per series and numbers MARYLAND CENTRAL PROPERTY.  Social Section Name of Section (Independent of Section Se	TO COLOR OF THE PROPERTY HAVE given between the country of the color o				Potricia Ann			Month	Day 2004	
Control   Cont	Social Scarch Wenter   Common   Commo					e street and number)		ath	4c. County of Death	
100. Store and Number   100. Control   100. Store and Number   100. Store an	Source   Continue				220 64 0604	I N APT C		in. Month, Day, Ye	9. Birth	ntry),
Specific Married (	Specific Married   Married   Control   Married   Control	land ow			10c. City, Town or L	ocation			10d. fnside City Limits	
Specific Married (	Specific Married   Married   Control   Married   Control	B Mary	ctor	Marylon NI.	Bol	HHIM			1 Yes 2 □ No	
Specific Married (	Specific Married   Married   Control   Married   Control	with the	Dire	- 11)/	1		10g.		ntry?	
Specific Married (	Specific Married   Married   Control   Married   Control	ne 23	eral		12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Ameri		
Elementary/Secondary (p. 12)   College (1-4of 54)   AU S & KLEPPY   VILLA TALLS (Norther Name (First, Models, Machan Sumane)	The part of the pa	980	urs after of	b		1 ☐ Yes 2 ₹ No If Yes, Give		erto Rican, etc.)	Specify: /	
Table   Same   Property   Marker   Property	The continue of the continue	2-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation 16a. Dece ade completed) (Give	edent's Usual Occupation  B kind of work done during most of w	vorking 16b		
Table   Same   Property   Marker   Property	The continue of the continue	121	within ene. then	duc		College (1-4or 5+)	1	10	Joh Jan	1 45 doz.
A   Donation   S   Other (Specify)   Ward   Argument   Sale   S	Continue   Continue		D 0 =			171-4-				00119
A   Donation   S   Other (Specify)   Ward   Argument   Sale   S	Continue   Continue	ylar	Menta Menta arked atic ev	To B	LAYMOND L	NATACE	Magle	THE SAND	EKS	
A   Donation   S   Other (Specify)   Ward   Argument   Sale   S	Continue   Continue	Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationship	/		3 11		
A   Donation   S   Other (Specify)   Ward   Argument   Sale   S	Continue   Continue		Healt Hem 2 Item 2	-	20a. Method of Disposition	20b. Place of Disp	osition (Name of )		1.00	
23. Part / Emery 4 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pack, or heart failure. List only one cause on each line.    Provided Back, or heart failure. List only one cause on each line.	23. Pert / Enter / Medical Examiner    Try   Striam   Pert   Continue   Pert	E	Pages nent of int: if			Hemoval from State	7. 1////	124/04/6	ountmore	May loss
23. Part / Emery 4 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pack, or heart failure. List only one cause on each line.    Provided Back, or heart failure. List only one cause on each line.	23. Pert / Enter / Medical Examiner    Try   Striam   Pert   Continue   Pert	3alt	Separtr Separtr mport iny inj		M. //-	, 5			ANTIS NO.	NETS HOME
Physician Medical Examiner    Physician Medical Examiner   Medical Exa	Privsician (Mocical Examinar)  The property of the property of		705 9 9	-	23a, Pert 1 Enter the disease, or com	plications that caused the death. Do not en	•		arradic, p	Approximate
Medical Examiner   Part   Pa	Necdical Examiner   Feathing in death   The past   Sequencially fest contribution   The past   Sequencial   The past   Sequencial   The past   Sequencial   Seq		Physician		sheck, or heart failure. List only	one cause on each line.	-			Interval Between Onset and Death
Sequentially fist conditions  Due to (or as a consequence of):  Due to (or	Sequentially 58 conditions, if you have been a supported to make the conditions of t		/Medical			, a				
Column   C	The standard of the standard o	4-	LXammer	ē	Sequentially fist conditions, if any, leading to immediate	b. Due to (or as a consequence of):				
Second   S	The part of the pa		cuted id ransit	ulme	Cause (Disease or injury that initiated events	<b>c.</b>				
FEMALE:   236. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   Month   Day   Year   Yea	The composition of the composi	90	sien ar		resulting in death) Last	Due to (or as a consequence of):				
23d. Date of delivery Month Day Year  24d. Was an autopsy 1 Day Year  24d. Was an autopsy 1 Day Year  24d. Was an autopsy 1 Day Year  24d. Day Day Day Day Day 1 Day Year  24d. Day Day Day Day Day Day Day Day Day Day	Section   Sect		5 S 6			d				
Cocaine use    1   Yes   2   No   3   Probably   4   Unknown	Cocaine use    Cocaine use   C	) XO	h certif ending use a	In/Me	23b. Was decedent pregnant		□Ectopic prognancy		23d. Date of delive	,
Cocaine use    1   Yes   2   No   3   Probably   4   Unknown	Cocaine use    Cocaine use   C		he deat the att	ysicia	1 □ Yes 2 □ No	4☐Pregnant at time of death 5		·	Month	Day Year
found at home    1625 Westwood Avenue, Baltimore, MD	found at hone    1625 Westwood Avenue, Baltimore, MD		s that t ned by e detai	y Ph	Part II. Dther significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	he cause of death?
found at home    1625 Westwood Avenue, Baltimore, MD	found at hone    1625 Westwood Avenue, Baltimore, MD	ords	equire en sig ould b	ted b	Cocaine use			1 ☐ Yes	2 ☑ No 3 ☐ Prot	pably 4 □Unknown
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found at home    1625 Westwood Avenue, Baltimore, MD	found at hone    1625 Westwood Avenue, Baltimore, MD	Tal F	n: Th fficete or, pag		25. Was case referred to medical		00 Plans (P	1 🗷 Yes 2 □		2 No
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found at home    1625 Westwood Avenue, Baltimore, MD	found at hone    1625 Westwood Avenue, Baltimore, MD	n o	ing Ph (fer th uneral			28a. Date of Injury 28b. Time of Injury	1.20a Work?		njury occurred	
found at home    1625 Westwood Avenue, Baltimore, MD	found at hone    1625 Westwood Avenue, Baltimore, MD	isio	death ctor: /	licat	3 ☐ Suicide 6 Could not b	OB ORGER of Injury At home form		INA L	and Number or Rura	al Route Number.
29a. Certifier  29a. Certifier  (Check only one)  29a. Certifier  (Check o	29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dadress of person who completed cause of death (Item 23a) (Type, Print)  Taska Z Given being M. D. 111 Penn Street, Baltimore, Maryland 21201	Diγ	s after Bl Director	Certif	4  Homicide determined	building, etc. (Specify)	noot, rustory, office	1625 Westwoo	d Avenue,Bal	Ltimore,MD
29b. Signature and title of certifier  29c. License number  O.C.M.E  29d. Date signed (Month, Day, Year)  MARCH 19, 2004	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Taska Z Given berg M. D. 111 Penn Street, Baltimore, Maryland 21201  State filed (Month, Day, Year)  A32. Registrar's Signature		e Hospit 24 hour e Funera letely fille		(Check only X Medical Exa	miner: On the basis of examination and/or in	th occurred at the time, date and pla nvestigation, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
Talsha & Greeker MA	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Taska Z Given berg M. D. 111 Penn Street, Baltimore, Maryland 21201  State filed (Month, Day, Year)  432. Registrar's Signature		To th within To th compl	Me	29b. Signature and title of certifier	10		29d. N	Date signed (Month,	Day, Year) 2004
	Taska Z Given berg M. D. 111 Penn Street, Baltimore, Maryland 21201				Jasta 3	Theerbey MD				
	State 31. Date filed (Month, Day, Year) 432. Registrar's Signature					A A		mra Marsel-	and 21201	
Till Telli Street, Burtinote, Maryland 21201	Registrar MAR 2 5 2004 Denies & Sports				31. Date filed (Month, Day, Year)	32. Registrar's Signature	books	WICL PRILY IC	TAT CICUL	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MARCH 11,2004 Dorothy DiPeppe 11:06 p <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev, Year) Sept 22, 1 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕅 F Yrs 88 Ĩ915 220-20-3404 Director Maryland Usuet Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits i Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at MD Baltimore t√ Yes 2 No Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3820 W. Coldspring Lane 21215 Funeral USA Pages 1 and 2 should be fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) beautician cosmotology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Graham Louis Dygert Gertrude E. Mershon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Kelser/daughter 5242 4th Street Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tment of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State <u>=</u> ፟ ፟ permit, Page Department ( Important: If any injury or once. ^ 4 

☐ Other (Specify) 21. Schatur of Euneral Service Licensee Ronald Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hypertensive athoroccurotic cardiovascular disease Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 5 Other (specify) been signed by the should be detached Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed?

1 Yes 2 A No certificate Attending Physicien: 25. Was case referred to medical examiner?
1 54. Yes 2 \( \triangle \text{No} \) funeral director, Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 V ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural death. 1 Yes 2 No s after death 2 Accident completely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital within 24 hours a 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME MARCH 16,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI MID 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

State Registrar

MAR 2 5 2004

2. Registrar's Signature

			Fieldse For Amend Item #19a	State of Maryl	and 4 Depa	artment of H	lealth and Me	ental Hygie	ne cegible.	00015
			For Amend Item #19a 1 - State Registrar MEND TTEM 30 1. Decedent's Name (First, Middle, La	per dvr g829 3/	25/04 Ge	tificate of l	Death	Reg. 2. Date of Death	No.ZUUL	3. Time of Death
	Physici /Medio	-1115	DOKOTHI-M.	MMSOLA				m march	15 200.	
10.7	Examin	er	4a. Facility Name (If not institution, giv. NoRTHWEST		CENTER		LS TOWN		4c. County of Dear	MORE
,	Funeral Director		210-12-4933	Sex 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jan 3, 19	9. Bin 22 Mar	thplace (State or Foreign buntry) y Land
	Aaryland f show ed at	ō	Usual Residence of Decedent           10a. State         10b. County           MD         Carrol	i	City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a-	Direct	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·	10f. Zip Code		10g.	Citizen of What Co	puntry?
	s 23a	srai	1825 Vincenza Dr		-115 123	Man Danidant -6115	21784	-t. Van an Na	USA	dana la dia a
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinal must be multiled at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1		was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Spec in, Mexican, Puerto P Specify:	city Yes of No- lican, etc.)	14. Race - Ame Black, Whit Specify: W	
15-0	iin 72 hou n "nature Actical E	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	durina most of workin	g 16t	. Kind of Business	Industry unk
212	ed with giene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 2		secretary	<b>y</b>			
land	uld be fife Aental Hy rked oth tic event	To Be (	17. Father's Name (First, Middle, Last Charles August				18. Mother's Name Helen	(First, Middle, Mail Charolet	•	
Mary	nd 2 shou alth and N 27 is ma	-	19a. Informant's Name/Relationship (		19b. Mailin 4638	Bartholo	and Number or Rural DW Road Sy	Route Number, Ci kesville	ty or Town, State, 2 , MD 217	
Baltimore, Maryland 21215-0036	Pages 1 a ent of Hez st: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ፟ Donation 5 ☐ Other (Specia	Removal from State	b. Place of Dispo cemetery, cren	sition (Name of natory or other place	Da	ate 200	. Location - City or	Town, State
Baltii	permit. F Departm Importar any injur		21. Signature of Funeral Service Lice Kona 1		or St Ba	Name and Address ate Anato	ss of Facility Omy Board MD 21201		altimore	Street
	nysician		23a. Pan1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the done cause on each line.	eath. Do not ent	er the mode of dying		respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	b. Due to (or as a cons	sequence of):					
3760,	ate be executed nysician and he burial-transit	cai	resulting in death) Last	Due to (or as a cons	sequence of);					
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate within a 42 hours after days.  To the Funeral Director Attenthis certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 18 months? 1 Yes 2 No	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
P.0	that the de led by the a detached t	Phys	9 Unknown		Mark and the sale			OO- Didute		
ords,	w requires tha s been signed I should be det	by	Part II. Other significant conditions of the state of the		BRA		an in Part I.	1 Tes		the cause of death? obably 4 Unknown
Division of Vital Records, P.O.	ysician: The law r is certificate has be director, page 2 sh	Completed	CIARONIC OB	STRUCTIVE	PULM	ONARY	DISEASE	24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of
VIII	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	TITLE .	Othe	26. Place of Death			
on of	ding Phys h. After this funeral di	tion; To	1 Yes 2 No  27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury	28c. Injury Work	4   Nursing Hom	e 5 ☐ Residence	6 □ Other <i>(Spe</i> onjury occurred	cify)
Divisi	To the Hospital or Attending Phwitins 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e con Stand of Initiation A	t home, farm, streecify)			Bf. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
_	e Hospital 24 hours e Funeral etely filled	Medical C	29a. Certifier (Check only one) (Check only one)	nysician: To the best of my liner: On the basis of exame and manner stated.	knowledge, death ination and/or inv	occurred at the tim restigation, in my op	ne, date and place, ar pinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of cartifier	Λ Λ	SICIAA	29c. License	inumber 2723		Date signed (Month	2004 1
			30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)	<del></del>			
	Sta	te	AVVERAHALLI M 31. Date filed (Month, Day, Year)	HARISH NORTHWEST	gnature		OWN,MD.			
	Registr		MAR 2 5 200		H. Ago	A.				

Baltimore, Maryland 21215-0036

Box 68780

P.O. |

Division of Vital Records,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 09320 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year KEVIN LOUIS ELLIS. SR. March 17, 2004 0100 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 3512 Hubbard Road Landover Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day Year) June 30.1964 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 (XM 2 □ F 39 Washington, DC 577-96-5311 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County ?) is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Director DC 1 X Yes 2 □ No Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4200 13th Street, N.E. 20017 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 3 Married 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Printer/Pressman Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe any injury or other traumatic event, sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wade Ellis Delores Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Ellis - Spouse 4200 13th St., NE, Washington, DC 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Domation 5 Other (Specify) Riverdale Park n/a Riverdale, MD 22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave., NW, Washington, DC 20011 ne disease, or complications that t failure. List only one cause on 2Aa Part 1 Enter caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate shock, or heart failu Immediate Cause (Final Interval Between Onset and Death Enysician resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): as IF FEMALE nse s 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Xes 2 □ No autopsy performed? page 1 Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) At SCEDE Certification: To 1 XYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury at 28b. Time 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 12:50 hours after death investigation ect 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ruryl Route Number, City or Ton St. 18 In by within 24 hours a Medical ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only ŧ 29b. Signal and title of certific 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AK 111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrer	State of		nd / Depa		t of H	lealth a		ental Hy		200	4 0932	
			Decedent's Name (First, Middle	, Last)					-		2. Date of De	ath		3. Time of Death	
	Physicia		Josie		С.			E	llis		Month March	Da 1		7:29 M	
	/Medic		4a. Facility Name (If not institution				4b. City.		Location of	of Death	Haren		: County of Deat		
10	Examin	er	Southern Marylan	-				into					rince Ge		
	Funeral		5. Social Security Number		7. Age (In yrs	. last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da	rth .	9. Birti	nplace (State or Foreign untry)	
	Director		437-88-7977	1 □ M 25 □ F	55	Yrs.	Months	Days	Hours	Min.	Dec.	31,	1948 Lou	isiana	
	D		Usual Residence of Decedent												
	the Maryland r 28s-f show notified at	_	10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits	
	e Ma	cto	Maryland   Prince	e Georges	C1	inton								1⊠Yes 2□No	
	ith th or 24	Director	10e. Street and Number				10f. Zip					10g. Ci	tizen of What Co	untry?	
0	23a	2	5117 Suitland Ro				207							es America	
20	ter dea	Funerai	11. Marital Status	12. Was Dece Armed For	rces?	J.S. 13.	Was Deced If Yes, spec	lent of H of Cuba	ispanic Orig n, Mexican	gin? (Spe 1, Puerto F	cify Yes or No Rican, etc.)	)-	<ol> <li>Race - Ame Black, White</li> </ol>		
36	hours after death with the Maryland tural; or ttems 23a or 28a-f show al Examinat must be notified at	by F	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 ☐ Yes If Yes, Giv Year or Da	9		1 ☐ Yes 2 ☑ No Specify:						Specify: B1	ack	
7,39 PM		b p			ates:	16a Daca	adanta Haral Convention					16h K	(ind of Business/	odustry.	
- 0 15	within 72 ene, than "nai	(Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired)							and of Businessy	ridustry					
1	× 5 4 7	шc	Elementary/Secondary (0-12)	College (1	Clerk						Fuel				
d 2	Hyg Hyg ent,	Ö	17. Father's Name (First, Middle,	Last)		1 000	JECTR	1	18. Mothe	r's Name	(First, Middle				
<u>a</u> n	ould be Mental arked c	0	Harrison Callaha	an					Gert	rude	Jones				
2	nd 2 should be Ith and Mental 27 Is marked of r traumatic sv	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a				er, City	or Town, State, 2	ip Code)	
<b>→ × × ×</b>	and 2 ealth a n 27 is		Roby Ellis Jr./F	lusband		5117	Suit	Land	Rd.	Suit	tland.	Mar	yland 20	746	
S 5	17. Father's Name (First, Middle, Last)  Harrison Callahan  Gertrude Jones  19a. Informant's Name/Relationship (Type, Print)  Roby Ellis Jr./Husband  20a. Method of Disposition  19Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signatur of Funzial Service Licensee  18. Mother's Name (First, Middle, Maiden Surmame)  Gertrude Jones  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z  20c. Location - City or Town State  20c. Location - City or Town State  21. Signatur of Funzial Service Licensee  22. Name and Address of Facility  Fort Lincoln, Funeral Home														
Roby Ellis Jr./Husband  20a. Method of Disposition    Date   Date   Date										Francis	ville, LA				
alti	mit. I partm portal inju		21. Signatur of Fungial Service		,		2. Name an				1				
CO m	Deg E		1 hon 2	Win	*	32	Pot B	nço	ln Fui Isburi	neral g Roa	Home	two	od. Marv	land 20722	
	- 条		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that co	aused the dea								July Hully	Approximate Interval Between	
	Physician		Immediate Cause (Final			- 1.		di	Man					Onset and Death	
	/Medical		disease or condition resulting in death)												
	Examiner		HERSONALS SERVICES OF		Hepai	toren	al s	420	100	3				11	
	n (% ,,,	ner	if any, leading to immediate	Due to (	or as conse	quence of):	-	39.00							
	be executed ician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.												
760,	be execute sician and burial-tran		resulting in death) Last Due to (or as a consequence of):												
376	ate by nysici he bu	icai	O									·			
Вох 68	requires that the death certificate been signed by the attending physisould be detached for use as the b	Physician/Medi	IF FEMALE:												
9	ith ce itend	an/i	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fet	al death 3	∃Ectopic pr						23d. Date of deli	very Day Year	
40	ne dea the at hed fo	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregn 9□Unkno	ant at time of	death 5	Other (sp.	ecify)					INCITUI	Oay 19al	
P. 9.	nat the d by the	Phy				audina ia sha			a in Dani I		220 Did	200000		the serves of death?	
1 0	ires tha signed I d be det	by	Part II. Other significant condition	ons contributing to de	ath but not re	suiting in the u	naerlying c	ause give	en in Part I.		İ	Yes 2		the cause of death?	
103	w requir been si should	ted										165 2			
) (	2 5 8	ompieted									24a. Was auto	osy	prior to c	opsy findings available ompletion of cause of	
	Th ate pag	Con									1 Yes	rmed? 2 ₩ No	death? 1 ☐ Yes	212 No	
$\sim$	Attending Physician: Th r death. sctor: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?		_			Lou			(Check only o				
) =	Physi this c	은	1 Yes 2 No	the state of the s		ER/Outpatier							6 □Other (Spec	ify)	
	ding F	on	27. Manner of Death 1 ☑Natural 5 ☐ Pendin		of Injury h, Day Year)	28b. Time of Injury		8c. Injury Work			8d. Describe	how inju	ry occurred		
15, vision	death death ctor: A	Certification:	2 Accident investig	not be	-41-1 444		M		Yes 2□1		Of Leasting (	C44		-17-1-1	
J.S.	or Attendated after death	iti	4 Homicide determine	ined 288. Flace buildir	ng, etc. (Spec	nome, farm, str ify)	eet, ractory	, опісе		4	City or To			al Route Number,	
10	To the Hospital or Attivithin 24 hours after de To the Funeral Direct completely filled in by the	2	29a, Certifier 1 Certifyin	g Physician: To the	hast of my kee	ovlodes doeth	b conversed	at the top	o data an	d place a	and object to the		\d		
<b>一</b>	Hos 24 hc Fun	ledical	(Check only 2 Medical one)	Examiner: On the ba	asis of examin	ation and/or in	vestigation,	in my of	pinion, deat	th occurre	d at the time,	date and	d place, and due	to the cause(s)	
_	o the ithin o the	Med	29b. Signature and title of certifie		ioi statos.		290	License	number			29d. Da	te signed (Month	Day, Year)	
			Roston t	= 1:4		1.0		D	3	,			3/20/	104	
	3		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			m 23a) /Turn	Priot\		3446						
			30. Name and address of person  RowtAV FAI			m 23a) (Type,	Gene	.α Δ	vo Su	it 3-	- 41 silv	~ S/	oring MO	20902	
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Sign		J Carry	<u> </u>	, , ,	-			0 9		
es.	Registr		BEAT C	× 000	1	Lo	1	1							
DH	MH 17 Rev 1/2	001	MAK &	5 2004	Red State	3.	1004								
						ORIGIN	AL								

		For State Registrar		State	of Maryl	and / Depa <i>Cer</i>	artment of tificate of	Health Death	and M h	lental Hyg R	iene 20	004	09322
		1. Decedent's Name (First,	Middle, Last)							2. Date of Dear	th Day	Year	3. Time of Death
Physic /Med		Greetre1	E. Elm	ore						March :			2:05 PM M
Exami		4a. Facility Name (If not ins					4b. City, Town,				4c. County		
		Hartley Ha				and the sale of th	Pocom		ity er 24 Hrs.	R Date of Right		ester	
Funera		5. Social Security Number	6. Sex	:  M 2∭2 F	7. Age (In	yrs. last birthday) Yrs.	Months Day			8. Date of Birth (Month, Day Jan 18,	Year) 1924	Alal	
Director		422-16-9595 Usual Residence of Deced	lent		00					Jan 10,	1724	лта	Jania
land ow		10a. State 10b. 0	County		100	. City, Town or Lo						1	0d. Inside City Limits
Man	to	MD Wo	rceste	r		Pocomok	e City						1 ☐ Yes 2¶ No
h the	Director	10e. Street and Number					10f. Zip Code			1	log. Citizen of \	What Coun	try?
th will	a	1006 Marke						2185				USA	
tems	Funeral	11. Marital Status		Armed F		in U.S. 13.	Was Decedent of f Yes, specify Cu	Hispanic ( iben, Mexic	Origin? (Spo can, Puerto	ecify Yes or No- Rican, etc.)	14. Had Bla	e - Americ ck, White,	
s afte	by Fi	1 ☐ Never Married 2( 3 🖫 Widowed 4 ☐ Di		1 ∐ Yes If Yes, G Year or			1⊡Yes 2∭ŽN	o Speci	fy:		Specif	v: wh	ite
2-UU3 72 hours a naturel', o	a pa		ecedent's Edu		Da( <del>0</del> 3.	16a. Dece	dent's Usual Occ	upation			16b. Kind of B	usiness/Ind	dustry
in 72	plet	(Specify only	highest grade	ompleted	(1-4or 5+)	(Give	kind of work don DO NOT use reti	e durina m	ost of work	ing			
C L L I 3-UU30 filed within 72 hours after death with the Maryland Hygiene ther than "naturel", or Items 23a or 28e-1 show ent, I'th Medical Exam har must be notitled at	Completed	Elementary/Secondary (	(0-12)	O	(1-401 5+)		homem	aker			own	home	
a filec	Be C	17. Father's Name (First, I								e (First, Middle,	Maiden Suman	ne)	
/Iand uld be fil Mental H irked oth	10 8	Robert I	Lee Web	ster						Russell			
and hard	4	19a. Informant's Name/Re		pe, Print)			-			al Route Numbe			Code)
and and mark		Jerry Elmor			100	336 0b. Place of Dispo		rive		ksville,	20c. Location		um Stato
Ore Jes 1 Tor H or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cren	nation 3 DF	temoval from	n State	cemetery, crei	natory or other p	lace)	ļ !	Date	200. Location	City of To	wii, Glaie
EIM : Pag tmen tent:		`4 □Donation 5 🖽 C			tate/		Name and Ada	tenns of En	l	2			
Baltimore, Maryland Z1Z15-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28e-1 show any injury or other traumatic event, Ite Madical Examinat must be notified at		21. Sharature of Euneral S	1//	11/1	Little	sor S B	altimore	tomy, MD	Board 2120			ore S	Street
		23a. Partt. Enter the dise shock, or heart failui	ease, or compl	ications that	caused the	death. Do not ent	er the mode of d	ying, such	as cardiac	or respiratory arr	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	o. Elot olling o	H	torke	Lin	Mein	ma	ni a				Onset and Death
/Medica		resulting in death)		Due t	or as a co	nsequence of):	7	21	nia Ver	4			
Examine		Sequentially list condition		, Ce	resh	som	Mar	Acc	1 der	r!			
<b>D</b> ≒	ner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ite 2	Due t	o (or as a co	nsequence of):							
ecute and trans	Examine	that initiated events resulting in death) Last	1	c. Due t	o (or as a co	nsequence of):							
60, be ex cian d		,,,,,,,		Duo (	0 (0) 43 4 00	11004201100 01/.							
8760 icate be e physiciar s the buria	dlcal		•	d									
Records, P.O. Box 68/60, The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregr	ant		outcome of pr		-10 10 50-50				23d. Da	ite of delive	ery
Box death cert attendin d for use	clar	in the past 12 month		4∐Pre	birth 2 gnant at time		∃Ectopic pregna ∃ Other (specify)				Mo	onth	Day Year
IS, P.O. It res that the designed by the a be detached for	hysi	9 Unknown		9□ Unl	known								
s that	by P	Part II. Other significant	conditions co	ntributing to	death but no	ot resulting in the u	nderlying cause	given in Pa	ırt I.				ne cause of death?
cords  require  been slg  should b	ed									1 🗆 Y	es 2, No	3 Prob	ably 4 Unknown
aw re	piet									24a. Was autop	sv	prior to co	psy findings available mpletion of cause of
The I	Completed									perfor	med? 2⊠No	death?	2 🗆 No
ian:	Be	25. Was case referred to examiner?	}						ace of Deat	th (Check only o	ne)		
of V hysic his co	2	1 ☐ Yes 2. No		1000000	Inpatient	2 ER/Outpatie	IL SELDON		Nursing Ho	ome 5 Resid			y)
ing P	on:	27. Manner of Death  ↑ ✓ Natural 5 ☐	Pending	28a. Da (M	te of Injury onth, Day Ye	ar) 28b. Time o		njury at Vork? ☐ Yes 2	□No	28d. Describe h	low injury occur	Teu	
Vision of Vital Attending Physician: or death. ector: After this certific by the funeral director.	icat	2 Accident 3 Suicide 6	investigation   Could not be	28e Pla	ce of Injury -	At home, farm, st				28f. Location (S	Street and Num	ber or Rura	il Route Number,
Division of Vital Records, for Attending Physician: The law requires the death.  Director: After this certificate has been signe in by the funeral director, page 2 should be it.	Certification:	4 Homicide	determined	bu	lding, etc. (S	Specify)	out, rustory, stric			City or Tow			
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	(Check only 2 1	Certifying Phy Medicel Exem	iner: On the	basis of exa	y knowledge, dea amination and/or ir	th occurred at the	time, date y opinion, o	and place, death occur	, and due to the or rred at the time, or	cause(s) and m date and place,	anner as s and due to	tated. the cause(s)
thin 2.	Med	one) 29b. Signature and Alle o	certifier (	~	anner stated		29c. Lice	ense numb	er		29d. Date signe	ed (Month,	Day, Year)
± 3 € 8			Sarra	× 1 N	11		D	-05	144	22	3-	16-	049
		30. Name and address of	person who o	ompleted ca	use of death	n (Item 23a) (Type	Print)	•	, (	S G N	185/		
	State	31. Date filed (Month, Da	y, Year)	32	Registrar's	Signature							
Regi		MAR	2 5 200	4	Bur	St A							

		-	For State Registrar	State of Maryland	d / Department of H Certificate of I			. 2004	• 09323
	Physici /Medic	al	Decedent's Name (First, Middle, Last)	Rosalie	Flynn	- N	Pate of Death Month De 1ACC 2	Yeer 4 200 County of Deet	
	Examin	er	4a. Fecility Name (If not institution, give si	PitaL	1	Me rue	40	N/A	n
	Funeral Director		5. Social Security Number 6. Sex	M 2DF 7. Age (In yrs. I.		If Under 24 Hrs. 8. D Hours Min.	rate of Birth Month, Day, Yeer, MC 29 19	9. Birtl Co	hplace (State or Foreign unitry)
	death with the Maryland ms 23a or 28a-f show Lidual be collified at	or	10a. State 10b. County	10c. City	RALTIMARE				10d. Inside City Limits
	or 28a-	irect	10e. Street and Number		10f. Zip Code		10g. Ci	itizen of What Co	ountry?
	ath wil	rai	12 -W. FOR			130	/ N-	U. S. /-	
920	or ite	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.: Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No	ispanic Origin? (Specify an, Mexican, Puerto Ricar Specify:	n, etc.)	14. Rece - Amer Black, White Specify:	
215-0036	는 문항	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	16a. Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired	ation during most of working 1)	16b. K	(ind of Business/I	Industry
21	77 75 2 20	Com	12+4	NIA	Sever			othing	Corb.
and	should be filed and Mental Hygi marked other imatic event,	To Be	Tosuch is Tzier	,		18. Mother's Name (First		1 Sumame)	
Maryland	s 1 and 2 should be filed f Health and Mental Hyg Item 27 is marked othe othar traumatic event,	ř	19a, Informant's Name/Relationship (Typ		19b. Mailing Address (Street a	and Number or Rural Rou	ite Number, City	or Town, State, Z	Zip Code)
	s 1 and 2 if Health if item 27 i			42 A	ace of Disposition (Name of	TAVE BALL	to. My	21830	Town State
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  → Burial 2 Cremation 3 Re  • 4 Donation 5 Other (Specify)	emoval from State	emetery, crematory or other place of Disposition (Name of Pack Ce	(0) 3 3 1 1	1 _	ocation - City or	rown, stele
Balt	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service License	illa	22. Name and Address HARTIEL M	ss of Facility Stell	A . A . **	11 Home 21734	CHD.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line.	Racramiel	hework	piratory arrest,  MK EM	.`^	Approximate Interval Between Onset and Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ		enous le	ukew	~ 14	oays.
,092	ite be executed ysicien and ne burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ience of):				
Box 68	The law requires that the death certificate tie has been signed by the attending physoage 2 should be detached for use as the	by Physiclan/Medio	23b. was decedent pregnant	3c. If yes, outcome of pregna	death 3 Ectopic pregnancy			23d. Date of deli	ivery Day Year
o.	that the de ed by the a detached f	ysic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5 ☐ Other (specify)				
4	w requires that been signed b should be deta		Part II. Other significent conditions con	. 11 1		en in Part I.	23e. Did tobacco 1 Tyes 2		the cause of death?
Vital Records,		Completed					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:	Oth	26. Place of Death (Ch			
	Phy this ral d	on: To	1 Yes 2 No ""  27. Nanyer of Death 1 Natural 5 Pending	28a. D. te of Injury (Month, Day Yeer)	28b. Time of 28c. Injury Work		5 Residence Describe how inju		cify)
Division of	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office		ocation (Street er City or Town, State		iral Route Number,
]	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce			wledge, death occurred at the timition and/or investigation, in my o				
	To the within 2 To the complet	Me	29b. Signature and title of certifier	elmo	29c. Licens	9 number	29d. Da	ate signed (Month	24, 2004
	X		30. Name and address of person who con NCN is W	mplefed cause of death (Item	23a) Type, Print) flace	Baltini	n MD	212	24,2004
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 5 2004	32. Registrar's Signar					

			1 - For State Registrar	State of	Maryland			of Health a		lental Hyg	iene g. No. 20	I N L	09324
	Dhusia	ian	1. Decedent's Name (First, Middle, L	ast)						2. Date of Deat	h		3. Time of Death
	Physic /Medi		Melissa	Firest						March	20,	2004	12:35 P <sup>M</sup>
7	Exami	ner	4a. Fecility Name (If not institution, gi 5225 Pooks Hill		oer)			wn, or Location			4c. Count		
	Forest				Age (In yrs. las	t hirthdayl	If Under 1	Bethesda Year   If Under		R Date of Righ		tgome	
	Funeral Director			1□M 2X1F	54			ays Hours	Min.	8. Date of Birth Month, Day DeC	Year) 1949	9. Birthpi Coun	ace (Stete or Foreign try)
	D		Usual Residence of Decedent  10a, State 10b, County										
	shov	5		077000	10c. City, 1	rown or Lo		D - 1 1 - 1				10	Od. Inside City Limits
	the h	ect	Maryland Montg	omery				Bethesd	d 		0- 02		1 □XYes 2 □ No
	death with the Maryland ms 23a or 28a-f show rmsal te notified at	<u>a</u>	5225 Pooks Hill	Road, Ap	t 1824	N	10f. Zip Co	2081	4	1"	0g. Citizen of	What Coun USA	try?
	death	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S.		Was Deceden	t of Hispanic Ori Cuban, Mexican		cify Yes or No-		ce - America	an Indian,
98	or its	F	1 ☐ Never Married 2 🗓 Married	Armed Force 1  Yes 2 If Yes, Give			tYes, specify 1□Yes 2D			Rican, etc.)		ck, White, e	ite
8	ural',	d by	3 Widowed 4 Divorced	Year or Date							Specif	y: 1911	1 66
21215-0036	filed within 72 hours after Hygiene. ther than "natural", or fte int, it a Medical Examina	Completed	15. Decedent's E (Specify only highest gi	ade completed)		16a. Deced (Give life. I	ient's Usual O kind of work of OO NOT use o	locupation lone during mos etired)	t of workin	ng .	16b. Kind of B	usiness/Ind	ustry
212	Jiene.	mo	Elementary/Secondary (0-12)	College (1-4	or 5+)			Teacher			ursery	Schoo	01
	be filed tal Hyg of othe	Be C	17. Father's Name (First, Middle, Las	,				1 _		(First, Middle, N			
yla	should band Ment	2	Jack Schi	nerin					anne		ckroy		
Maryland	CA 00 70 10	1	19a. Informant's Name/Relationship							Route Number,			
	1 and Health em 27 Ither tr		Ed Firestone  20a. Method of Disposition	(spouse			POOKS			1804 N,			
Baltimore,	Pages nent of I int: If the		1 🖾 Burial 2 □ Cremation 3 [  4 □ Donation 5 □ Other (Speci	Removal from Sta	ate cem	etery, cren	natory or other	place)	March	n 25	0c. Location -	·	
altir	permit. F Departme Importan sny injur		21. Signature of Funeral Senfice Lice		luran		Cemet	ery ddress of Facilit	200		Johnst	own,	PA D A
ä	Departiment of the service of the se		Mad X	1						allings , Pasade	runera na Mi	1 HOII	ie, P.A.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	reations that cau	sed the death. (	Do not ente	or the mode of	dying, such as	cardiac or	respiratory arre	st,		Approximate Interval Between
	Physician	2 (	Immediate Cause (Final disease or condition	UU	MUL	TIL	216						Onset and Death
	/Medical Examiner												
Ď	Examilie	_	Sequentially list conditions,										
_	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	ce on:								
1	execu in and ial-tra	Exai	resulting in death) Last  Due to (or as a consequence of):										
8760	cate be executed obysician and the burial-transit	dlcal		_ d									
9	ertifica ing ph e as th	Φ :	IF FEMALE:		-	-	3						
Box	death certifii e attending p ed for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea	ath 3	Ectopic pregn					e of deliver	
o.	0 0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4∐ Pregnant 9□ Unknown	t at time of death	5 □	Other (specify	/)			Moi	nun L	ay Year
۵.	the See the		Part II. Other significant conditions	contributing to death	but not resultin	g in the un	derlying cause	given in Part I.		23e. Did toba	cco use contr	ribute to the	cause of death?
Records,	quires n sign ald be	d by						-			3.0		oly 4 □Unknown
000	law requinas been si 2 should l	Completed								24a. Was an	24b. V	Vere autons	y findings available
autopsy prior to completion of										oletion of cause of			
Vital	icien: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?					26. Place	of Death	Check only one		Yes 2	□ No
of <	hys this al dir	은	1 Ves 2 No	Hospital: 1  Inpa		Outpatient	3□ DOA	Other: 4 Nur	sing Hom	e 5 🗌 Residen	ce CCthe	er (Specify)	SCENE
	ding F h. After funera	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Ir (Month, I		D. Time of Injury		njury at Work?	28	d Describe hou	inium annum	a d	From
Division	Attending r death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not b	0	Injury - At home,	1230f		1 □ Yes 2 N	_	18TH F	100R =	TO GR	UND
<u> </u>	iel or Attendi s after death. el Director: A ed in by the fu	Certification;	4 Homicide determined	building,	etc. (Specify)			T TO GRUS		Sf. Location (Stre City or Town,	State) 527	25 POC	OKSMILL RO
	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in Direction		29a. Certifier 1□ Certifying Ph	vsician: To the be	st of my knowled	ice death	occurred at th	e time, date and	nlace an	d due to the car	se(s) and mai		ed.
	To the Hi within 24 To the Fu completel	edical	(Check only one) 2 Medical Exar	niner: On the basis and manner	or examination	and/or inve	estigation, in n	ny opinion, death	occurred	at the time, date	e and place, a	and due to th	ne cause(s)
	To To Corr	Σ	29b. Signature and title of certifier	1	1/		29c. Lic	ense number		290	I. Date signed	(Month, De	y, Year)
1			( / /		1 oh	2		O.C.M.	Ε.	I.	March 2	21, 20	04
Annual Section 19	6		30. Name and address of person who	completed cause o	death (Item 23a			reet F	lalti	more, Ma	arar I ara	2120	1
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature			LOCE, L	~~ <u>(.1</u> 1	more, Pic	т. А топ 10	2120	<b>T</b>
1/3	Registra		MAR 2 5 20	100	wa	B	Anne	61					

			Please I  1 - State Registrar	State of Maryla	ind / Depa		Health and I	Mental Hygi	iene	004	0000
	Physici	an	1. Decedent's Name (First, Middle, Last) Birdie	Floyd				2. Date of Deat Month	h Day	Year 2004	3. Time of Death 2:40 P M
	/Media		4a. Fecility Name (If not institution, give s			4b. City, Town, o	or Location of Deat	March		ty of Deeth	2.40 1
4	Examir	er	Mariner of Glen Bu				Burnie		Ann	ne Arur	ıdel
	Funeral Director		5. Social Security Number 6. Sex		rs. last birthday) 73 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Jan. 17	Year) 1931	9. Birthpla Count	ace (Stete or Foreign ry) KY
	Maryland -f show lied at	tor	Usual Residence of Decedent  10a. State 10b. County  WV Mineral	10c.	City, Town or Lo		ington			10	od. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the	al Director	10e. Street and Number Route 2 Box 3			10f. Zip Code	26710	10	Og. Citizen of	f What Count USA	ry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other then "netural", or Items 23e or 28e-f show empty injury or other traumatic event, it is Medical Examinational be multied at Once.	Completed by Funeral	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (S ean, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		ace - America lack, White, e sify: Wh	
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occur kind of work done	pation during most of world)	rking	16b. Kind of	Business/Inde	ıstry
121	vithin ne. hen	mpf	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	<i>bo not use retire</i> Homemake			Но	ousehol	d
22	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)			пошешаке		ne (First, Middle, M			u
an	d be sontal	To Be	Matt Gros	is			Bess	ie V	iars		
Maryland 21215-0036	id 2 shoull lith and M. 27 to mar!	1	19a. Informant's Name/Relationship (Ty) Thomas H. Floyd	pe, Print) (spouse)		•		ural Route Number, ngton, WV			Code)
	f Hea item		20a. Method of Disposition		. Place of Dispo	sition (Name of matory or other pla	Marc	h <sup>Date</sup> 24	20c. Location	- City or Tov	vn, State
Baltimore,	permit. Page Department o Important: If eny injury or once.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature Funeral Servia Lights	$\bigcap$ M	eadowri	dge Cernet 2. Name and Addre	tery 2	004 E	ngs Fu		Home, P.A.
**	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ne dause on each line.		er the mode of dy	ng, such as cardia		est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or as a cons	equence of):						
P	e be e scute sician and s burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons							
68760	icate be e physician s the burial	20		1							
P.O. Box (	The law requires that the death certificate ate has been signed by the attending physipage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopic pregnanc □ Other (specify) _	y		1	Date of deliver Month [	y Day Year
	quires that n signed b uld be deta	þ	Part II. Other significant conditions con	-	-	nderlying cause gr	ven in Part I.		acco use co	ntribute to the	e cause of death?
Division of Vital Records,	The law requir cate has been si page 2 should I	Completed						24a. Was ar autops perform 1 Yes 2	y ned?	were autop prior to com death? 1 \( \text{Yes} \) 2	sy findings available apletion of cause of
Vita	icien: Sertific ector.	Be	25. Was case referred to medical examiner?	lospital:		0:		ath (Check only one			
n of	ing Phys	lon: To	27. Manner of Death  1 Matural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju	4 Lanuising r	dome 5 ☐ Reside 28d. Describe ho			)
Divisio	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)		163 2 110	28f. Location (Sti City or Town		nber or Rural	Route Number,
	ie Hospita 124 hours ie Funera ietely fille	edical (	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the to vestigation, in my	ime, date and place opinion, death occu	e, and due to the ca urred at the time, da	iuse(s) and nate and place	manner as sta e, and due to	ited. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	Ma			se number	1		ned (Month, D	
)	6	1 8		ompleted cause of death (I	tem 23a) (Type,	Print)	55506		03,	/23/	104
		ate	31. Date filed (Month, Day, Year)	ompleted cause of death (I	RFLA,	* thigh	way I	ore Leno	170-	y kn.	1 21/22
	Regist	rar	MAR 2 5 2	MA Preser	pie p	1 Ann	1.1 3				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 09326 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 21,2004 2:00A Robert Edward Friend March /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 2021 N. Bentalou Street
5. Social Security Number 6. Sex 7. Age 9. Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 212-30-0084 Yrs. Dec.8, 71 MD Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exercity or must be notified at 1 XYes 2 No Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 2021 Bentalou Street N. 21216 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U Armed Forces? 1 Q Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1951 120 Yes 2 No If Yes, Give 1954 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 þ Specify: Black 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
McMillan Blodel/ 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Atlas Container 12th Machine Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental if Health and Menta Bernard Alfred Friend, Sr. Fannie Mayo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert B. Friend - Son 2021 N. Bentalou St. Balto., MD 21216 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important; If ite
any injury or ot
once. Arbutus Memorial 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify 3/26/04 Balto. Co., MD

22. Name and Address of Facility Nutter Funeral Homes, Inc. Park 21. Signatur of Funeral Service Licer 23a. Part. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. 2501 Gwynns Falls Pkwy. Balto., MD 21216 Approximate Interval Between Onset and Death Heart Failure Immediate Cause (Final Congestive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiongspathy 10 4 2045 Restrictive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manger of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 024566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eters, MD, Cardiology Section, UA Hospital, 10 N Greenest, Balt, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

DHMH 17 Bev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 09327 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 19, 2004 **Physician** 6:15 pM Joseph Wilson Gonzales /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's County Hospital Cheverly Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 1 (Months, Par) 2 2 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 82 577-16-6770 Washington DC Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 □ No Maryland Prince George's Mitchellville 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 0 #350 10450 Lottsford Road 20721 USA Itams 23e death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 42-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 ¹by ▶ 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☑ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d other then "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. Accountant Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie Regina Joseph Wilson Gonzales is marked 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 i Linda Jones - Stepdaughter 1009 Danbury Dr., Bowie Maryland 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o important: If any injury or once. Fort Lincoln Crematory 3/24/04 Brentwood, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Myslin T. Klobert M01322 3401 Bladensburg Rd, Brentwood MD 20722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ Yes 2 No 3 Probably 4 Unknown cate has been sig . page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No certificate 20 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only of Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification; To funeral 27. Manner of Dealt 28a. Cate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifus 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Hospital Drive Cheverly, Maryland 20785 James Catevenis, MD 31. Date filed (Month, Day, Year) 32. Registrar Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) MARCH 5:35 AM **Physician** Rebecca Leslie Greenwood /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SAINT AGNES HEALTHCARE N/A 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F 88 Yrs. 220-22-7393 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show the Medical Exercicer must be notified at 1 Yes 2 □ No Director Baltimore MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21223 U.S.A. 2129 Penrose Avenue or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Dry Cleaner 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Establishment Counter Clerk 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Trunit. Pages 1 and 2 should be file
Continuent of Health and Mental Hy
Important: If item 27 is marked oth
Into your other traumatic event **Emma** Charlie Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 Christine J. Smith-Daughter 3532 Kingspoint Road Randallstown, MD Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Garrison Forest 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Owings Mills, Veteran Cemetery 3/29/04 \* 4 ☐ Donation 5 ☐ Other (Specify) MD 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Lic ensee 2501 Gwynns Falls Pkwy. Balto., MD 21216 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n each line. Approximate Interval Between Onset and Death Immediete Cause (Final INSUFFICIENCY **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ONGESTIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner COLITIS use as the burial-transit CLOSTRIDIUM that initiated events resulting in death Last Dea to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No certificate 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Alter Hospital or Attending Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide 29a. Certifier 1 🕱 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Umnsleienica MARCH 23 2004 MARYZAND 2122 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAINT AGNES HEALTH CARE, 900 CATON AVENUE, BALTIMORE LARYSA KWINTKIEWICZ 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 5 2004

		•	1 - For State Registrar	State	of Marylan	-	artmen			and M			200	1 19329
f	Physici	an	1. Decedent's Name (First, Middle,								2. Date of De Month March	ath		3. Time of Death
	/Medic	al	LaDawn Mar		imber)		4b City	Town or	Location of	of Death	March		2004 County of Dea	5:10 AM M
	Examin	er	Millenium Sout	-	anosi)				ater	502		١.	e Arun	
ı	Funeral Director		5. Social Security Number 220–16–1847	6. Sex 1 ☐ M 2 🏋 F	7. Age (In yrs. 51	last birthday) Yrs.	If Under Months	_	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da July 2.	th y, Year)	9. Bir Co Pe	thplace (State or Foreign buntry) nnsylvania
	pu *		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Maryla fed at	tor		Arunde1			ewate	r						1 ☐ Yes 2X No
	th the	irec	10e. Street and Number				10f. Zip					10g. Citiz	en of What Co	ountry?
	s 23a	rai	144 Washington		and and Francis III	6 12	Man Dogge		1037	ain? (Car	naitu Vac os No		USA 4. Race - Ame	anican Indian
36	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or Items 23s or 28e-f show ant, the McGical Examinat must be motified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie  3 □ Widowed 4 ☒ Divorced	Armed F	2 X No		was Deced If Yes, spec 1 ☐ Yes		n, Mexican	gin : (Spe i, Puerto	ecify Yes or No Rican, etc.)	1	Black, Whit	
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	han "	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	life.	<i>DO NOT u</i> s disab	e retired	)			OF.	n home	
[Z D	be filed within tal Hygiene. d other than event, the M	Be Co	17. Father's Name (First, Middle, L	_ast)			u I Sab	Icu	18. Mothe	r's Name	(First, Middle			
/Ian		To B	Ralph Green								elia Hu			
Maryland	Cl co == @		19a. Informant's Name/Relationsh Sherie M. Ritch		*		ng Address Woodl				n Burni			
ē,	t and Health tem 27 other tr		20a. Method of Disposition	110/51500	20b. F	Place of Dispo	sition (Nan	ne of	T		Date		cation - City or	
ē	Pages nent of int: if i		1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ₩ Other (Sp		1 State	эвтнөсөгү, стөг	matory or o	iner piac	9					
Baltimore,	permit. Pages 1 and Department of Healinportent: if item 2 any injury or other 2006.		21. Sign three of Funeral Service to Ronal d	icensee	Billery	S S	2. Name an tate <i>l</i> altimo	d Addres Anato ore,	s of Facilit Omy B MD	y oard 2120	1 <sup>655</sup> W.	Ba1	timore	Street
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to	each line.	uence of):	•				The espiratory a			Approximate Interval Between Onset and Death More Hun
8760,	icate be executed physician and s the burial-transit	Ical	resulting in death) Last		o (or as a conseq	quence of):								
O. Box 6	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	1 Live	utcome of pregna birth 2 Feta gnant at time of c nown	al death 3	⊒Ectopic pr ⊒ Other <i>(</i> sp					2	3d. Date of de Month	livery Day Year
ds, P	uires that signed bi id be deta		Part II. Other significant condition  Ascites		death but not res Gasho:	•		ause give	en in Part I.	ng_		obacco us Yes 2		the cause of death?
Division of Vital Records,	rsician: The law requires that the contrificate has been signed by the director, page 2 should be detached.	Completed by	Renal Insu	ebbicie v				19			24a. Was auto perio 1 Yes		death?	utopsy findings available completion of cause of 2 No
/ita	Iclan: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only			
<u></u>	Physi r this c ral dire	5	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date	e of Injury	ER/Outpatier 28b. Time o		8c. Injury Work	4 L NU	-	me 5 🗌 Resi 28d. Describe			icify)
on	ttending P death. ctor: After y the funera	atior	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investig	3	nth, Day Year)	Injury	М		k? Yes 2 ☐	No				
Divis	al or Attending Physician: s after death. al Director: After this certification by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	208. Plat	ce of Injury - At h ding, etc. (Speci	ome, farm, st	reet, factory	, office			28f. Location ( City or To	Street and wn, State)	Number or R	ural Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Medical (	29a. Certifier 1 Certifyin (Check only 2 Medicel I	g Physicien: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my o	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and	and manner as place, and due	s stated. e to the cause(s)
	To ti To ti comp	×	29b. Signature and title of certifier	C-	ne	cena	<	D 5	o number			3/6	signed (Mont	th, Day, Year)
			30. Name and address of person 5851 - Deal	e Chu	urchte	on R	Print) (		N. C	] S )-ea	URAN	ND-	20	751
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 2		Pagistrar's Signa		Soul	,						

_		da l	1 - For State Registrar			Marylar	nd / Depa		Health and I	Mental Hy	giene Reg. No.	2004	0933
	Physic /Medi Examir	cal		GI If not institution	ERTRUDE n, give street and num		ZALESK		GILDEN , or Location of Death		22 <sup>Day</sup>	2004 County of Death	
	Funeral Director		STELLA M 5. Social Security N 219-32-	0325		7. Age (In yrs.	last birthday) O Yrs.	If Under 1 Year Months Day			gh, <sup>v</sup> , 191	3 9. Birth	BALTIMORE oplace (State or Foreig ontry) MD
	he Maryland 28a-f show officed at	Director	Usual Residence of 10a. State	10b. County	ALTIMORE	10c. Cit	ty, Town or Lo	HERVILLE					10d. Inside City Limits
ď	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Iteme 23e or 28e-f show event, if a Meulsid Ever it is mast be rediffed at	Ineral Dir	10e. Street and Nur  16 SEMI  11. Marital Status		RIVE		.S. 13.	10f. Zip Code  Was Decedent of Yes, specify Cu	21093 f Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No		en of What Cou 4. Race - Ameri Black, White,	U.S.A.
1:30 p.m 215-0036	72 hours afte natural', or it	Be Completed by Funeral	1 Never Marri	4 Divorced	led 1 Tes and If Yes, Give Year or Da	2 X No	16a. Deced	1 ☐ Yes 2 🔀 N	o Specify:		5	Specify:	WHITE
21	filed within 7 Hygiene. other than "r	Comple	Elementary/Seco	ndary (0-12) 12	College (1-	4or 5+)	life. I	RIETOR	e during most of worred)  18. Mother's Nam			ESALE N	OTIONS
2004 Aaryland	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other than other treumatic event, IL a M	To B	JOSEPH  19a. Informant's Na			D		g Address (Stree	DORA et and Number or Ru	ral Route Numb	er, City or	(UNO	
MARCH 22, Baltimore, M	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other to		20a. Method of Disp	cosition Cremation 5 Other (Sp		20b. P	Place of Dispo emetery, cren UDAS AC	sition (Name of natory or other pi CHIM) AN . Name and Add	ISHE 3/2	Date 4/2004 OL LEVII	20c. Loca VSON	ation - City or To ROSEDAL & BROS.	own, State E, MD, INC.
	Physician /Medical Examiner	Examiner	23a. Pert1. Enter the shock, or head immediate Cause (disease or condition resulting in death)  Sequentially list concause. Enter Unde Cause (Disease or that intitated events resulting in death) Linear Cause.	reditions,	Due to (o	ch iine.	ULAR A( uence of):		STERSTOWN ving, such as cardiac			SVILLE,	Approximate Interval Between Onset and Death
P.O. Box 68760,	death certificate e attending phy: id for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☑ 9 ☐ Unknown	months?		th 2 ☐ Fetal nt at time of de	death 3	Ectopic pregnan Other (specify)	су		23	d. Date of delive	ery Day Year
Records, P.	requires been sign should be	Completed by Ph	Part II. Other signifi	icant conditio	ns contributing to dea	ith but not resu	ulting in the un	derlying cause g	iven in Part I.		/es 2□	No 3□Prob	he cause of death?  pably 4XIUnknown  psy findings available
	The ate h	Be Comp	25. Was case referr	red to medical					26. Place of Deat	autop perfo 1  Yes	rmed? 2 <b>X</b> No	prior to condeath?	mpletion of cause of
Division of Vital	ding Phyon After this funeral di	Certification: To	1 ☐ Yes 2 🛣  27. Manner of Death 1 🛣 Natural 2 ☐ Accident 3 ☐ Suicide		28a. Date of (Month, ation		28b. Time of Injury	28c. Inju	uryat ork? ⊡Yes 2 □ No	ome 5 🗌 Resid 28d. Describe h		Other (Specify occurred	HOSP‡CE
Divi	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		4 ☐ Homicide  29a. Certifier	determin	ned 289. Place o building	g, etc. (Specify	v)	occurred at the	ime, date and place	City or Tow	m, State)	nd manner as at	al Route Number,
	./	Medical	(Check only one)  29b. Signature and	Z   Medicel E	xeminer: On the bas and manne	is of examinat	ion and/or inv	estigation, in my	opinion, death occur	red at the time, o	date and pl	signed (Month,	the cause(s)
	Sta	te	DR. TA	RIQ MAI	32. Reg		NEY VAI	Print) LLEY RD.	TIMONIU	M, MD 2	1093		
DHI	Registr MH 17 Rev 1/20		MAR	2 5 200	4 Bronda	18	god	9					

MARCH 22, 2004

GERTRUDE GILDEN

			State of Maryland / Department / Department / D	artment of Health and I	Mental Hygie	ne No2004 09331
	Dhysisi		Decedent's Name (First, Middle, Last)	Haynes	2. Date of Death , Month	3. Time of Death
	Physici /Medic Examin	al le	Margaret L,  4a. Facility Name (If not institution, give street and number)  Johns Hopkins Bayview Medical Center	· · · · · · · · · · · · · · · · · · ·	January	5 2004 15 0 7 M  4c. County of Death  N/A
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 220 - 22-5736 1 M 208 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye April 29, 19	9. Birthplace (State or Foreign Country)  9. Birthplace (State or Foreign M)
	daryland f show	or	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Lo	Smore		10d. Inside City Limits 1 ☐Yes 2 ☐ No
	or 28a-	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
ဖွ	72 hours after death with the Maryland natural', or items 23a or 28a-f show iteal Exame ar must be molified at	Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	ZIZIZ  Was Decedent of Hispanic Origin? (S  If Yes, specify Cuban, Mexican, Puerl  1 □ Yes 2 □ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
215-0036	72 hours a natural, c	ted by	3 ∰Widowed 4 □ Divorced Year or Dates:  15 Decedent's Education 16a Dece	dent's Usual Occupation	166	Specify: Black  D. Kind of Business/Industry
21215	filed within 73 Hygiene. Ither than "m int, the Medi	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	kind of work done during most of world DO NOT use retired)  Domestic Wor	ker	Private
Maryland	Mental Merked o	To Be	17. Father's Name (First, Middle, Last) Daniel Staten	E	ne (First, Middle, Mai	Kett
altimore, Mar	ges 1 and 2 s t of Health ar If item 27 is or other trau		Mrs. Edwing Green daughter 1.51  20a. Method of Disposition  1. Properties 2 Companion 3 Chemoval from State cemetery, creation 20b. Place of Disposition competery, creation 3. Chemoval from State cemetery, nd chemoval from State cemeters and	osition (Name of matory or other place)	Date 200	Battmare MD 21213 Location City or Town, State
Baltir	permit. Pag Department Important; any injury once.		21. Signature of Funeral Service Licensee	2. Name and Address Facility e	Fun eras	SerVICE FIFT
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
,092	death certificate be executed e attending physician and od for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	brillation	APPROVED BY MEDICA	36 hours 36 hours
O. Box 68	that the death certifica led by the attending ph detached for use as th	Physician/Medi		CERTIFIUM ] □Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Δ.	juires that n signed by	by	Part II. Other significant conditions contributing to death but not resulting in the usual barral hematowna	inderlying cause given in Part I.		co use contribute to the cause of death?  2 No 3 Probably 4 Honknown
Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed	dementia		24a. Was an autopsy performed	
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	24	ath (Check only one)	
on of	ng ffe	tlon: To	1 X yes 2	1 3 DOA 4 I Nursing P	28d. Describe how i	e 6 Other (Specify)  njury occurred  cel1
Division	To the Hospital or Attandii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)  Residence	reet, factory, office	City or Town, S	t and Number or Rural Route Number, tate) zerne Ave., Balto., MD
	e Hospit 24 hours e Funera etely fille	Medical (	29a. Certifier (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge, deal 2 ☐ Medical Exeminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the caus	e(s) and manner as stated.
	To th within To th	Me	29b. Signature and title of Certifier	29c. License number		Date signed (Month, Day, Year) NURY 5, 2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, Bayview Medical Center, 4940 E		stein, M Baltimo	o. Johns Hopkins re, marly and 21224
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 2 3 2004  33 Registrar's Signature			

			For State Registrar	State of Mar	yland / De	epartment of Certificate of	f Health and l of Death	Reg	ene 200L	
	Physici /Medic		Decedent's Name (First, Middle, Last     Lydia	P.		Hubbard		2. Date of Death Month 3 19		3. Time of Death 12:30p M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give  3900 Eierman Ave 5. Social Security Number 248-01-5040	e	In yrs. last birtho	Ba.				nplace (State or Foreign untry)
W	ryland show		Usual Residence of Decedent  10a. State 10b. County		0c. City, Town o					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ith the Ma or 28a-f	Director	Md. NA		Bal	.timore	le	109	g. Citizen of What Co	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Proportional: If them 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event. It a Medical Exactinal must be notified at ance.	by Funeral I	3900 Eierman Ave  11. Marital Status 1  Never Married 2 Married 3  Widowed 4 Divorced	12. Was Decedent Ev. Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:	er in U.S.		206 of Hispanic Origin? (S Cuban, Mexican, Puerl No <i>Specity:</i>	pecify Yes or No- o Rican, etc.)	USA  14. Race - Ame Black, White	
21215-0036	within 72 hour ene. than "natural" te Medical Ex	Completed b	15. Decedent's Edu (Specify only highest grace Elementary/Secondary (0-12)	ucation	(C	ecedent's Usual Oc Give kind of work do fe. DO NOT use re Seamstres	nne during most of wo tired)	rking	Sb, Kind of Business/	
ana	t be filed ntal Hygi ed other: event.	Be Co	17. Father's Name (First, Middle, Last)		William			me (First, Middle, Ma		
Maryland	id 2 should th and Mer 27 is mark traumatic	2	Josh  19a. Informant's Name/Relationship (T)  Mary Moody	ype, Print) Daughter	19b. N	failing Address (Str			City or Town, State, 2	ip Code)
Baltimore,	Pages 1 an ient of Heel nt: If Item 2 ry or other		20a. Method of Disposition  1 🔀 Burial 2 □ Cremation 3 □ I  4 □ Donation 5 □ Other (Specify,	Removal from State	cemetery,	isposition (Name of crematory or other L1 Mem. G	place) arden 3-2		Dc. Location - City or Dundalk, M	
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licens	wan	دع	22. Name and Ad	.H. East	Baltimo 1101 E. N	North Ave.	21202
	Physician and /Medical Examiner but strength of the private transit strength of the private tr	Examiner	23a. Part1. Enter the disease, or companions, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	mache consequence of	Cane	dying, such as cardia	c or respiratory arres	i,	Approximate Interval Between Onset and Death  3
O. Box a	the death certii y the attending iched for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death	3 □Ectopic pregni 5 □ Other (specif)			23d. Date of deli	very Day Year
ords, r	The law requires that ite has been signed b vage 2 should be deta	by	Part II. Other significant conditions co	entributing to death but	not resulting in t	he underlying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,		Completed							prior to death?  No 1 ☐ Yes	topsy findings available completion of cause of
n or	ding Physician: Th h. After this certificate funeral director, pag	tlon: To Be	27. Manner of Death  1 Natural 5 Pending	Hospital: 1  Inpatient 28a. Date of Injury (Month, Day 1	28b. Tir	ne of 28c.	Other	ath (Check only one) Home 5 Residen 28d. Describe how	ce 6 □Other (Spec	sity)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farn (Specify)	n, street, factory, off	ice	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	te Hospit 24 hours te Funera	edical C		vsicien: To the best of hiner: On the basis of e and manner state	xamination and/					
	1-1	Me	29b. Signature and title of certifier  (Wellier	) rous		29c. Lic	cense number	9	d. Date signed (Month	7
	(3)		11 CALLES C. 2.	AMD	37		Is Rel	Balti	11 e Ml	21211
	Sta Regist		31. Date filed (Month, Day, Year)	32. Pegistrar	s Signature	Angel !				

ORIGINAL

			1 - For State Registrar	State of Maryland / [	Departmen Certificat				iene 2004	09333
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last CHINA	VICTORIA	HAWKI		i Dank	2. Date of Death Month MARCH 2	Day Year 23 2004	3. Time of Death $10:40 \text{ A}^{\text{M}}$
j	Examin	ner	4a. Facility Name (If not institution, give MARINER HEALTH O.  5. Social Security Number 6. Se	F NORTH ARUNDEL	GL.		TE nder 24 Hrs.	8. Date of Birth	4c. County of Death ANNE ARU  9. Birth	
	Funeral Director		246-28-1999 <sup>1[</sup> Usual Residence of Decedent	□M 2∏F 79	Yrs. Months	Days Hou	urs Min.	(Month, Day,	0 1925 Nort	th Carolina
	ihe Marylar 28a-f show offilied at	Director	10a. State 10b. County  Md. Anne Ar  10e. Street and Number	undel 10c. City, Tow	n or Location  Glen Bu			10	Og. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 No
130	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, I'm Medical Exain, or inval by motified at	by Funeral Dir	1108 Loenard Dri  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	VC  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	,	21060 dent of Hispanic city Cuban, Mex		cify Yes or No- Rican, etc.)	U.S.A.  14. Race - Amer Black, White Specify:	ican Indian,
21215-0030	filed within 72 hou Hygiene. ther than "nature int, the Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		Decedent's Usua (Give kind of wo life. DO NOT u	rk done during se retired)	most of workii	ng 1	Montgomery	
yland	2 should be file and Mental Hy is marked oth aumatic event	To Be (	17. Father's Name (First, Middle, Last)  Horace Russell	Maltba		18. M	E1ma		Hodges	
re, mai	1 and 1 and 1 eaith 1 m 27 1 her tr		Donna Jane Hunt  20a. Method of Disposition	(Daughter) 1		ard Dri	ive, G1	en Burn	City or Town, State, Zi ie, Marylat 20c. Location - City or T	nd 21060
Saitimor	permit. Pages Department of I Important: If ite any injury or o'		1  Burial 2	Pine	Grove Ce	emetery ad Address of F				ch Carolina
6	Physician		23a Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	not enter the mod	e of dying, such	Road, n as cardiac o	leral Hoi Pasaden: r respiratory arre	me P.A. a, Maryland st,	Approximate Interval Between Onset and Death
,00/80	/Medical Examiner  ciew and privial-transit	ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to manufalate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	oty.					
O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pi 5 □ Other (sp				23d. Date of deliv	ery Day Year
cords, P	requires that the een signed by th hould be detache	by	Part II. Other significant conditions co	ntributing to death but not resulting in	n the underlying c	ause given in P	art I.	23e. Did toba	acco use contribute to l	he cause of death?
T O	The la ate has page 2	Completed						24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
ion or vital	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner?  1 Yes No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation				Nursing Hon	(Check only one ne 5  Resider 8d. Describe how	nce 6 Other (Speci	(y)
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory	, office	2	8f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	the Hospi nin 24 hour the Funer npletely fill	Medical	(Check only 2   Medicel Exami	sician: To the best of my knowledge ner: On the basis of examination an and manner stated.	d/or investigation	, in my opinion,	death occurre	ed at the time, da	te and place, and due t	o the cause(s)
	2 1 2 8	~	29b. Signature and title of certifier	pro	<b>-</b>	D 19			d. Date signed (Month,	
-00	Sta	ate.	30. Name and address of person who compared to the state of the state	ompleted cause of death (Item 23a) (  10	AIN HEG	HONT	Suite	206	Auch 23, FLEN BURN	3106
	Registr		MUR 2 5 2004	Denger D	spark	2				-130/

			For State Registrar	State of Ma	ryland / De <i>C</i>	partment of F ertificate of	lealth and N <i>Death</i>	Mental Hygi	ene 20	04	09334
		s: &	Decedent's Name (First, Middle, Last					2. Date of Death	1	3.	. Time of Death
9-1	Physici /Medio		MARGARIT E	HUMPHA	Reus			March	19 20	Year	4:30 AM
	Examin		4a. Fecility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County		
			12 5NOG	- LAGO	n CT.	MIDE	DIE RIVE	(	Ba	TINOR	k
30	Funeral		5. Social Security Number 6. S	9x 7. Age	(In yrs. last birthda	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			(State or Foreign
	Director		213-70-0037	UM, JEF	Yrs			JAN 22	1927		MD
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. I	Inside City Limits
	Aaryli f sho	ō	MO BALT	13000	Mid	Mr RIVER					1 Yes 2 No
	289-	rect	10e. Street and Number	1 voice	lact of	10f. Zip Code		10	g. Citizen of W	/hat Country?	
	3a of	0	12 SNUG L	A Green C	7	21	220		_	. S. A.	
	Jeath Ins 2:	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S. 1	3. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race	- American II	ndian,
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f show other traumatic event, it a Medical Erania at mula Le notified at	by Fur	t ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 N  If Yes, Give  Year or Dates:	ő	If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	Rican, etc.)	Specify:	k, White, etc.	Ē
9	72 ho	Completed	15. Decedent's Ed	lucation	16a. De	cedent's Usual Occup	pation	ring 1	6b. Kind of Bu	siness/Industr	ry
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yla	Men Men Marke	ဥ		RNST			Helen				
Maryland	12 shon and 7 is m		19a. Informant's Name/Relationship			ailing Address (Street		100			
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do not	enter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	App	proximate erval Between iset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	. CONGE	3VIVE	CANT	PAIL	INE		OII.	36( 2110 062(11
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
ab?	Par.	-	Sequentially list conditions,	b. Due to (or as a	consequence of):	CTENSI	0 ~				
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289		a a		U							
Box	death certifl e attending   d for use as	NA NA	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome of		3 (			23d. Date	of delivery	
	death e atte	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at		3 □Ectopic pregnancy 5 □ Other (specify) _	<i>'</i>		Mon	th Day	Year
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	ires that signed I d be det	by	Part II. Dther significant conditions of	ontributing to death bu	t not resulting in the	underlying cause giv	en in Part I.		acco use contri		
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n o	ath. rr: After t	on:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injur	y Wor		28d. Describe how	w injury occurre	od	
isio	ttend death stor:	icat	2 Accident investigation 3 Suicide 6 Could not b		nu. At home, form	street, factory, office	Yes 2 □No	28f. Location (Stre	not and Numbe	e or Bural Ba	uto Numbor
Division of	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	4 Homicide determined	building, etc	(Specify)	street, ractory, ornor		City or Town,	State)	or ribrar rio	ote (voinber,
_	spital ours nerel filled	S S	29a. Certifier 1 Certifying Ph	ysician: To the best of	if my knowledge, de	eath occurred at the tir	ne, date and place.	and due to the car	use(s) and mar	ner as stated	d.
	• Hos 24 h e Fur letely	ledical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/or	investigation, in my o	pinion, death occur	red at the time, da	te and place, a	nd due to the	cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	10	11/1	29c. Licens			d. Date signed	(Month Day,	Year)
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	,/		30. Name address of person who			oe, Print)	10 - 18 -	1.	Ro	BAL	TIMORE
			J535A)	CONNI	clly p	MD /	0/156	TCON	NU	MD:	21220
-15	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature						
	Regist	ar	MAR 2 5 2004	Bankon	6	don't					

DHMH 17 Rev 1/2001

ORIGINAL

Arthur L. Hugh Maryland 21215-0036

Baltimore, P.O. Box 68760, of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item #10e,12, per Fli, 6830, 4,27,7014, gap Certificate of Death Registrar Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1215 DM Mar Ch Physician 2004 Arthur Leroy Hughes, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Baltimore Baltimore City Sinci Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. | Nov. | 22, 1926 Birthplace (State or Foreign
 Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2 □ F 77 Director 212-20-2970 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel", or items 23s or 28s-f show any injury or other traumatic event, the Machinal Examinal must be putified at once. 1 XYes 2 □ No Directo N/A Baltimore 10e. Street and Number 11 Heights 1226 Liberty Heights Avenue 10g. Citizen of What Country? 10f. Zip Code 21207 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No If Yes, Give 11/2/45 Year or Dates: 2/14/47 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Expeditor College (1-4or 5+) Elementary/Secondary (0-12) S Postal Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Arron H. Hughes Maude L. Goodwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 19a. Informant's Name/Relationship (Type, Print) Arthur L. Hughes, Jr.-Son 12508 Woodbridge Ct. Mitchellville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Arbutus Memorial Park 3/22/04 \* 4 ☐ Donation 5 ☐ Other (Specify) Balto. Co., MD 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Lice 2501 Gwynns Falls Pkwy. Balto. MD 21216 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Dneumonia ASpiration 14 days **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus 2 No 3 Probably 4 □Unknown 1 Tes venous stasis ullers 24b. Were autopsy findings available prior to completion of cause of death? oxtremity 24a. Was an autopsy performed? ibrillation Chronic 1 ☐ Yes 2 ☐ No 1 Tes 2**/**Z or Attending Physician: completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 1 Natural 5 Pending 1 Tes 2 No investigation 24 hours after death. Funeral Diractor: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12ES-000 MD march 14,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Ruth L. Merid 2401 W. Belvedere St., Balto., M.D. 21215 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004 MAR 2 5

			State Amend Items 25,2	State of Marylan 27,28a-f per ME	d / Departmen ,G829-03/20/00 ertificat	t of Health and	Mental Hygiene Reg. No.	2004	09336
Ë			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day		3. Time of Death
	Physicia /Medic		AKHOD	HARRIS			Feb 10	7 2004	1110 M
	Examin		4a. Facility Name (If not institution, give stre	et and number)  Ceneral	4b. City,	Town, or Location of Deal	nty Columbia	HUNG	URD.
	Funeral Director		5. Sociel Security Number 6. Sex	7. Age (In yrs.	last birthday) If Under Months  Yrs.	1 Year   If Under 24 Hrs Days   Hours   Min		3 9. Birth	place (State or Foreign intry)
	pur	Ì	Usuel Residence of Decedent  10a, State 10b, County	10c, Cit	y, Town or Location				10d. Inside City Limits
	Maryla a-f sho	tor	MD Howard		Co	umbla			1 Tyes 20 No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number	o Pond	10f. Zip	Code DIVAS	10g. Cit	izen of What Cou	intry?
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21215-0036	od within glene. er then'	Completed	Elementary/Secondary (0:12)	College (1-4or 5+)	life. Do NOT U	K	FO	od Se	rvice
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental than the Mental th	To Be	17. Father's Name (First, Middle, Last)	PRS		18. Mother's Na	me (First, Middle, Maiden	Sumame)	
lary	2 should and Mer is marke		19a. Informant's Name/Relationship (Type	Print)	19b. Mailing Address	(Street and Number or R	ral Route Number, City o	or Town, State, Zi	Code)
	1 and 2 Health tem 27		20a. Meth : of Disposition		Place of Disposition (Na		Date 20c. Lo	ocation - City or T	own, State
altimore,	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State	cemetery, cran atory or o	Centery 2-	5-04 Coo.	KStille	$MO \cdot$
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	<i>\$</i>		23a. Part1. Enter the disease, or complications, or hear failure. List only one immediate Cause (Final	tions that caused the deat cause on each line.			c or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	quence of):	n Bo USM		./	DAYS
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ion	nding th. r: After e fune	ation	1 □Natural <del>5 □ Po</del> nding 2 X Accident investigation	(Month, Day Year) 02/01/2004	Unknown M	28c. Injury at Work? 1 ☐ Yes 2≹ No	Slipped on i	ce and fe	11
Division	I or Atte after dea Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci Residence	nome, farm, street, factor	ry, office	28f. Location (Street ar City or Town, State 9645 White Ac	э)	
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			30. Name and address of person who com 9/0/ Chorry 31. Date filed (Month, Day, Year) MAR 2 0 2004	opleted cause of death (Itel	m 23a) (Type, Print) /	Course	55 A1201	070	8
3		ate	31. Date filed (Month, Day, Year)	37 Registrar's Sign	ature forth				
	Regist	rar	MAR 2 0 2004	DEPLINE A	14				

		•	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F			giene Reg. No. 2	004	09337
	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea	Day	Yeer	3. Time of Death
	/Medic	al .		laught		Ab Cib. Town	.1	MARCH		2004	08:10 Am
	Examin		4a. Facility Name (If not institution, give Saint Joseph	Medical	Center	4b. City, Town, or	Tow	son			imore
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	and wo		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
	Maryl	tor	Md. Baltimor	·e	Towson						1 ☐ Yes 2 ☐ No
	or 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
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20	al', or	þ	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Speci	hy: Wh	<b>i</b> te
9500-6121	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itams 23e or 28e-f ehow event, I're Medical Examinar mant be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Giv	edent's Usual Occup	during most of w	vorking	16b. Kind of E	Business/Inc	dustry
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	spits ours iera fille	edical C	(Check only 2   Medical Exam	iner: On the basis of	of my knowledge, dea f examination and/or in	th occurred at the tin	ne, date and pla pinion, death oc	ice, and due to the corred at the time, of	cause(s) and m	anner as st	ated. the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner sta	aled.	29c. Licenso			29d. Date signe		
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	10		30. Name and address of person who o	ompleted cause of d	leath (Item 23a) (Type	, Print)			- 1		-
			MARCEL ING D ALI 31. Date filed (Month, Day, Year)		M. D. 76	01 OSLER	DRIVE	TOWSO	N. MARY	/LAND	21204
AS-	Sta Registi		MAR 2 5 20		UK A	ande					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 09338 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** NOON MARCH 20, 2004 6:50p /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2433 DRUID HILL AVE. BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** Days Hours 1 □ M 2 0 F Director 212-60-6493 50 10-22-1953 MARYLAND Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "naturel", or iteme 23e or 28a-f ehow the Medical Examinar must be notified at MD. N/A BALTIMORE 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2433 DRUID HILL AVE. 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 💢 No 1 ☐ Never Married 2 ☐ Married If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK Be Completed by 3 ☐ Widowed 4 🎇 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12-ASSISTANT PROGRAM DIRECTOR CHIMES INC. marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ie merked of 8 JAMES PITTMAN JANET HAMMOND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE MOORE(SISTER) 2635 GATEHOUSE DR. BALTIMORE, MARYLAND 21207 if item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Peges 6 1X Burial 2 □ Crema permit. Pege Department o Importent: If any injury or NEW CATHEDRAL CEMETERY3-26-2004 \* 4 ☐ Donation /5 □Øther (Specify) BALTIMORE, MARYLAND 21. Signature of Europeal Service Licensee JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death . Enter the disease, or complications that caused the death. It or heart failure. List only one cause on each line. Do not enter the made of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** astatio let MOORS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to for as a consequence of Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed the burial-transi Due to (or as a consequence of): attending physicien Physician/Medical as use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 autopsy performed? 1 Yes 2 ANo or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 Yes 2 Yo 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation by the t 2 Accident after death Director: 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in within 24 hours a To the Funerei I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

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Records,

Vital

Division of

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20014 Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8:50 Pm Physician 200 SHARRONA JOHNSON /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) Examiner STELLA MARIS @ MERCY HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2 🛛 F Yrs. MARYLAND 4-14-1961 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. Count ahow 7 is marked other than "natural", or ferms 23s or 28s-f shor traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No N/ABALTIMORE Director MD. SHAPPONA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 817 N. KENWOOD AVE. 21205 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK þ 3 € Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. -11--0-HOUSEWIFE DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be OHUSON, s 1 end 2 should be Health end Mental ROSKEY L. JOHNSON JEANETTE HENDERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4711 ELISON AVE. BALTIMORE, MARYLAND 21206 JEANETTE JOHNSON (MOTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 Cremation 3 Removal from Department ARBUTUS MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 3-26-2004 BALTIMORE, MARYLAND 21. Signature of Funeral Service LicenseeGUINEVERE REDD 22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical LANG Examiner Due to (or as a consequence of): Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown mo defrue þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30cName and address of person who completed cause of death (Item 23e) (Type, Print)

within 2

trar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

3/22/2004

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARCH 21, 2004 BARBARA JEFFERSON 6:45pm /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE
Under 1 Year If Under 24 Hrs. 8. Date of Birth
The Days Hours Min. 0 7 - 0 7 - 1 9 4 6 JOSEPH RITCHIE HOSPICE 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sax **Funeral** Months 1 □ M 2 □ F MARYLAND 57 Yrs Director 218-44-5070 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show the Medical Examiner roughts notified at BALTIMORE 1 Yes 2 No N/A Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? LINWOOD AVE APT II 21213 USA 1304 N. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates: ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK δ "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STATE GOVT HOUSEKEEPING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental 2 EVELYN HINTON CHARLES JEFFERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m eny injury or other treum once. 1304 N. LINWOOD AVE APT II, BALTO, MD 21213 CHARLES JEFFERSON, SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Removal from State 03-26-04 MOUNT ZION MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO, MD 21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VASCactive intestinal peptide Physician neuroendocrine /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. if yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of or Attending 1/Natural 5 Pending death. investigation 2 Accident with n 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier No M D24170 March 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 E. Tsc MD Hospice 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Geneva MAR 2 5 2004 Registrar

JACLARCA

Raymond Edress Jackson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-01870 Unpend Item#23a,27,Pen/EG830,4/7/0428 Certificate of Death RJ 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Raymond Edress Jackson 2004 March 15. 1:37 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 22355 National Circle Lexington Park St. Mary's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, OCt. 16 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1937 Months **Funeral** 1 M 2 □ F 66 GΑ 252-58-5775 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Lexington Park St. Mary's Maryland 1 XYes 2 No Director 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code 22355 National Circle 20675 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Black 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sailor U.S. Navy Unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jackson J. Percy Williams P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Herman Jackson (brother) 4611 Ken Knight Dr. North, Jacksonville. FL 32299 20b. Place of Disposition (Name of cometery, crematory or other place) March 22 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) 2004 Second Mt. Zion Cem. Albany, Georgia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. Dal 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Atherosclerotic Cardiovascular Disease Physician resulling in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 5 Other (specify) been signed by the should be detached □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ∏ Yes 2 ∏ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 Tyes 1X Yes 2 □ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: Y Yes 2 No 1 Inpatient 2 ER/Outpatient Certification; To 3 DOA funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance as selected.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and tille of certifier 29d. Date signed (Month, Dey, Year) 29c. License number O.C.M.E. March 16, 2004 M.1). Jawha ! Treenherg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Z Gireenberg M.D Tasha

Registrar

State

31. Date filed (Month, Day, Year)

MAR 2 5 2004

Aparks!

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2001 09342 For State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month **Physician** Valentine Jackson Shirley 03 2004 4:00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Landover 2704 Kelner Drive If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 F Crawfordsville Director 06-27-1935 410-56-4875 68 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar mastice neithed at 1 XYes 2 □ No Landover Prince George's Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 USA 2704 Kelner Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher DC Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lillie Roberson John Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Landover, MD 20785 permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trat. 000.0. 2704 Kelner Dr. John D. Jackson - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 03-25-2004 Brentwood, MD 22. Name and Address o Facility Ft. Lincoln Funeral Home 21. Signature of Feneral Service Licenses 3401 Bladensburg Rd Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Multiple Myeloma 4 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a considuence of Examiner any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death in the past 12 mont Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2 12 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has 1 Yes 2 No certificate 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No this 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred e Hospital or Attending Programme 1.24 hours after death.
e Funeral Director: After the letely filled in by the funera After t 5 Pending 2 🗌 No 1 🗌 Yes investigation 2 Accident 6 Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 29b. Signature 03-24-2004 D51260 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9E17 Baltimore, Maryland 22 South Green Street Rm N 31. Date filed (Month, Day, Year) MAR 2 5 2004 Registrar's Signature State 10/15.11 Registrar

		1	For State Registrar	State of Maryland		tment of H ificate of L			giene Rag. No.	004	09343
I	Physicia /Medic	ın	1. Decedent's Name (First, Middle, Last)	Koch				2. Date of Dea Month	Day	2004	3. Time of Death
	Examin		4a. Facility Name (If not institution, give st	for Hasp	pital	Ba	Location of Deat	e /	2	ounty of Death	11
	Funeral Director		5. Social Security Number 6. Sex 216-10-6615  Usual Residence of Decedent	7. Age (In yrs. /as	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		, Year) 17	9. Birthol County MARY	* *
	ith the Maryland or 28a-f show or mutified at		10a. State 10b. County  MD BALTIMORI		Town or Loca HILLEI					10	0d. Inside City Limits 1 ☐ Yes 24☐ No
	uth with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number 1822 WENDOVER ROAD			10f. Zip Code 21234			10g. Citize	n of What Coun	try?
336	er des Items ner m	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☆ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: WWTT	lf '	as Decedent of H Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		. Race - America Black, White, e pecify: WH	
1215-0036	within 72 hours aft ane. than "natural", or the Medical Exami	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give ki life. Di	nt's Usual Occup ind of work done of NOT use retired	during most of wo	rking		of Business/Inc	
Maryland 21	should be filed withir of Mental Hygiene. Imarked other than imatic event, the Mental than imatic event, the Mental than imatic event, the Mental than imatic event, the Mental than imaginatic  events.	To Be Co	12TH GRADE  17. Father's Name (First, Middle, Last)  HARRY KOCH		ELEC.	IRICIAN		me (First, Middle, A GAWLIK			
-	1 and 2 should I Health and Men Iem 27 ie marke other treumatic		19a. Informant's Name/Relationship (Type DOLORES MARKIEWICZ	NIECE	5911	SHADY S	and Number or R PRING AV		DALE,	MD 21	237
altimorë	t. Pa tmer rtent		20a. Method of Disposition  1	moval from State MORE	netery, crema ELAND I	tion (Name of atory or other place) MEM PAR Name and Address	к 3/2	6/2004	HILLE		MD
Bal	permii Depar Impor any ir		21. Signature Funeral Service License	Husp	8	521 LOCH	RAVEN B	LVD. TO	WSON,		IOME, P.A. 286 Approximate Interval Between
	Physician /Medical Examiner	25°	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	p cause on each line.  Due to (or as a conseque	My			nfair			Interval Between Onset and Death
8760,		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Create of Ingl.) that initiated events resulting in death) Last	Due to (or as a conseque							
Box 6	eath atter for u	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnand  1 Live birth 2 Fetal of  4 Pregnant at time of dea	death 3⊡E	Ectopic pregnancy Other (specify)	,		23	d. Date of delive Month	ory Day Year
ds, P.O	requires that the dieen signed by the hould be detached	ρ	Part II. Other significant conditions con	ributing to death but not result	ting in the und	derlying cause giv	en in Part I.	1	obacco use /es 2 🗆		ne cause of death? ably 4 Unknown
Vital Records,	e law has b je 2 s	Completed								prior to cor death?	psy findings available inpletion of cause of
/ita		Be	25. Was case referred to medical examiner?	ospital:		3□ DOA Oth	or	ath (Check only o			
of	ing Phys	tlon; To	27. Manner of Death	1 inpatient	Outpatient 28b. Time of Injury	28c. Injur Wor	4 Li Nui Sirig	Home 5 Residence Residence Page 1			v)
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Ton		Number or Rura	l Route Number,
	e Hospital 24 hours e Funerel etely filled	ledical C	29a. Certifier Check only one) Certifying Phys	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tire estigation, in my o	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) a date and p	nd manner as st lace, and due to	tated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Scin		29c. Licens	e number 3 895	56 7	29d. Date	signed (Month,	Day, Year)
	10,		30. Name and address of person who co	elmb, 560		rint) R	wen	, BaH,	mov	e, Mo	2,2004 ug/mel
	St Regist		31. Date filed (Month, Pay, Year) MAR 2 5 20	32. registrar's Signatu	8	out .	/				

			For State Registrar	State of Maryla		oartmen e <i>rtificat</i>				giene Reg. No. 200	
		=	1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea	ath Day Year	3. Time of Death
	Physici /Medic		BERNARD	GERS0	N		KAPLA	.N	March	22 200.	
	Examin		4a. Facility Name (If not institution, give	e street and number)	1	4b. City,	0 /	cation of Death		4c. County of Dec	
	1		Sinai Hospy	al of Bull	non	14.11=-1		Under 24 Hrs.	7		N/A
- 1	Funeral		5. Social Security Number 6. S			y) If Under Months		Hours Min.	8 Date of Bird (Month, Da FEB.6,	y, Year) 9. 61 1012	rthplace (State or Foreign Country)
	Director		212-07-8056 Usual Residence of Decedent	λ	91 Yrs.				FEB.0,	1913	טויו
	iand		10a. State 10b. County	10c. C	ity, Town or	Location					10d. Inside City Limits
	Mary Feb	jo	MD BAL	TIMORE	BA	LTIMOR	RE				1 ☐ Yes 2 No
	r 28a	rec	10e. Street and Number			10f. Zip	Code			10g. Citizen of What C	ountry?
	72 hours after death with the Maryland "nature!", or Iteme 23a or 28a-f ehow idical Examinat must be notified at	Funeral Director	2408 SUGARCONE	ROAD				21209			U.S.A.
an	deat	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1	3. Was Dece	dent of Hispa	anic Origin? (Si Mexican, Puerto	pecify Yes or No o Rican, etc.)	- 14. Race - Am Black, Wh	
	after or ite	E	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 Yes		Specify:		Specify:	WHITE
5-0036	hours after turel', or ite	d by	3 X Widowed 4 □ Divorced	Year or Dates:	1 10 5					ACL Kind of Business	
5	nati	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	/G	cedent's Usui ve kind of wo b. DO NOT u	rk done duri	n ing most of wor	king	16b. Kind of Busines	s/industry
2121	within lene. then	E D	Elementary/Secondary (0-12)	College (1-4or 5+)		LANCE		ER		SELF EMPL	OYED WRITER
d 2	filed Hygid Sther ent, I		17. Father's Name (First, Middle, Last,	)			18	3. Mother's Nam	ne (First, Middle,	Maiden Sumame)	
an	should be filed within and Mental Hygiene. marked other than imatic event, the Mental	To Be	ISRAEL		KAPL	.AN		IDA		(บ	NOBTAINABLE)
Serner d	ges 1 and 2 should be filled within 72 hours after death with the Maryla it of Health and Mental Hygiene. If item 27 ie marked other than "naturel", or iteme 23a or 28a-f ehov or other treumatic event, II a Medical Examinar must be notified at	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	ailing Address	(Street and	Number or Ru	ral Route Numbe	er, City or Town, State,	Zip Code)
	and 2 ealth a n 27 is		ILENE D. COHEN /	DAUGHTER	24	108 SU	GARCON	E ROAD	- BALTI	MORE, MD 2	1209
Je,	of Health Item 27 other tr	1	20a. Method of Disposition		Place of Dis cemetery, of	sposition (Na erematory or c	me of other place)	Ì	Date	20c. Location - City of	r Town, State
Baltimore,			1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specil	y) HA	R SINA	I CEM	ETERY	3/24	1/2004	OWINGS M	ILLS, MD
alti	Department mportant mportant plury injury		21. Signature of Funeral Service Lice	See		22. Name ar				NSON & BRO	
<u> </u>	20E 2 9		/ Carl					ERSTOWN			E, MD 21208
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do not	enter the mod	de of dying,	such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Presmon	:9						3wk
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):						
4	****	_	Sequentially list conditions, if a ry, leading to immediate cause. Enter Underlying	b. Qualo (or as a consi	anues off						
_	ted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
	be executed sicien and burial-transit	xar	that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):						
760,		calE		d							
68	leath certificat attending phy I for use as the									1	-
ŏ	h cert endin use	S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		3 ⊟Ectopic p	regnancy			23d. Date of d	
	deat deatt	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of 9☐ Unknown		5 Other (s				Month	Day Year
9.	that the de ed by the a	by Physician/Med	9 Unknown					in Danil	22a Dide	abassa usa saatsibuta	to the cause of death?
Cipivision of Vital Records, P.O. Box 68	res tha igned l		Part II. Other significant conditions	contributing to death but not re	esuning in th	e ungerlying i	cause given	mranı.			Probably 4 Dunknown
oro	w require been sig	eted									
ခွ	e law has b	ompleted							24a. Was auto	psy prior to death?	autopsy findings available completion of cause of
a F	yeiclan: The is certificate hi director, page	O							1 Yes	2 1 No 1 Ye	es 2001/0
Vit.	eliciar centif recto	o Be	25. Was case referred to medical examiner?	Hospital:		*inat 2 0			ath (Check only o	one) dence 6 □Other <i>(Sp</i>	and it
o	Phys r this sral di	<b> </b>	27. Mann of Death	28a. Date of Injury	28b. Tim	e of	28c. Injury a Work?			how injury occurred	ocity)
o	ding th. Afte	諪	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Inju	м		s 2□No			
N.S.	Atter r dea ector by the	iffe	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm	street, factor	y, office		28f. Location ( City or To	Street and Number or I	Rural Route Number,
<u>ة</u> ر	s after bi Dire	Certification;	4 Torriedo	Building, old. (Spo							
1	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		(Check only 2 Medical Exa	hysician: To the best of my k miner: On the basis of exami							
	thin 2. the I mplet	Medical	one) 29b. Signature and title of certifier	and manner stated.	3	29	c. License n	number		29d. Date signed (Mo.	nth, Dey, Year)
	# ¥ # 8	1	•	MI	1	4	REI	-000		March 22	, 2004
	18	1	30. Name and address of person who		ر em 23a) (T∨	pe, Print)					,
	1.		Ryan Katz	mi) S	ina.	Hospita	l of	-000 Balt.	more		
	St	ate	31. Date filed (Month, Day, Year)	32, Registrar's Sig	nature	9 -	/-				
- 0	Regist	trar	MAR 2 5 20	U4 Deliver	O 18	De la constante de la constant					

	1 - For State Registrar	State of Maryland	I / Department of Certificate of			ene 9. No2 0 0 4	09315
	Decedent's Name (First, Middle, Las.)	0			2. Date of Death	3.1.2.0.0.4	3. Time of Death
Physician /Medical	MARGARET.	N. LIND	th City Town	or Location of Death	MARCH 2	Day Year 21, 2004	1455 P M
Examiner	4a. Fecility Name (If not institution, give 7616 MARS AVENUE	street and number)	BALTIM	ORE CITY		NIA.	
Funeral Director	5. Social Security Number 6. Se 212-78-1266	7. Age (In yrs. Ia	Yrs. If Under 1 Yea Months Day		8. Date of Birth (Month, Day, ) Jan 28	Year) 9. Birthp Coun	lace (State or Foreign
how	Usuel Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location			1	0d. Inside City Limits
with the Mar t or 28e-f st be notified Director	MD NI	n	BALTIMORE 101, Zip Code		100	g. Citizen of What Coun	1 ZYes 2 No
23a or	7616 MARS	Are		21234		U.S.	A .
within 72 hours atter death with the Maryland ene. then "natural; or items 23e or 28e-f show he Medical Examiner must be natified at pmpleted by Funeral Director	11. Marital Status  1 Never Married 2 Married  2 Vidowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Hispanic Origin? (Spe ban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, of Specify:	
s 1 and 2 should be filed within 72 hou if Health and Mental Hygiene. Item 27 is marked other then "nature other traumatic event, the Medical E To Be Completed	15. Decedent's Ed (Specify only highest grad	de completed)  College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retii	e during most of worki red)	ing	6b. Kind of Business/Inc	dustry
ifiled within Hygiene. other therent. The Ment.	17. Father's Name (First, Middle, Last)	NIA	Home	MP KCR 18. Mother's Name	(First, Middle, Ma	Ho Me	
should be nd Mental marked o umatic eve	George Will	S		Unka	1621		
and 2 sho ealth and n 27 is my ser traums	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailing Address (Street)		AUSTON	City or Town, State, Zip	
Pages 1 and 2 nent of Health : int: If item 27 i	20a. Method of Disposition	nemoval from State	ace of Disposition (Name of metery, crematory or other p	lace)		Oc. Location - City or To  BALFO. M	wn, State
permit. Pages Department of Importent: If i eny injury or once.	*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licens		PREVIOUS CRME  22. Name and Add  HARTIEU Mi	ress of Facility	A FUNERA	11 Home CI	
405 • a	25a. Par 1. Enter the disease, or comp shick, or heart failure. List only	lications that caused the death.	17527 has	toro RD	190 (to 100	21034	Approximate Interval Between
Cate be executed / Medical Examiner et the burial-transit dical Examiner dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	a. Atterioscler  Due to (or as a conseque  Due to (or as a conseque  C	ence of):	ascular Dis	sease		
The law requires that the death certificat the has been signed by the attending phycage 2 should be detached for use as the completed by Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal ( 4 □ Pregnant at time of dea	death 3 Ectopic pregnan	су		23d. Date of delive Month	ry Day Year
w requires that been signed by should be deta	Part II. Other significant conditions co	ontributing to death but not resul	ting in the underlying cause o	iven in Part I.		acco use contribute to th	
					24a. Was an autopsy performe	24b. Were autop prior to condeath?	osy findings available inpletion of cause of
ysicien: s certific director,	25. Was case referred to medical examiner? 1 □Xes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DOA	26. Place of Death		ice 6 XOther (Specify	AT SCENE
	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of 28c. Injury W		28d. Describe how		,
Hospital or Attending P Pours after dean. Funeral Director After tely filled in by the funeral tely filled in by the funeral fical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, offic	9	28f. Location (Stre City or Town,	eet and Number or Aural State)	Route Number,
To the Hospital or At within 2- hours after or To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of my know iner: On the basis of examination and manner stated.	riedge, death occurred at the on and/or investigation, in my	time, date and place, a opinion, death occurre	and due to the cau ed at the time, date	use(s) and manner as state and place, and due to	ated. the cause(s)
	29b. Signature and title of certifier		29c. Lice	ose number		d. Date signed (Month, LIARCH 22, 2	
12	30. Name and address of person who c	completed cause of death (Item	23a) (Type, Print)  111 Penn Stre	et, Baltin	more, Mar	cyland 2120	1
State Registrar	31. Date filed (Month, Day, Year) WAR & 5 2004	32. Registrar's Signatu	5 Sparks	,			

			For State Registrar	State o	f Marylan		artment of h		nd Mental I	Hygier Reg. I	200	) 4	09346
			1. Decedent's Name (First, Middle	, Last)					2. Date of Month		Day	Year	3. Time of Death
	Physicia /Medic		Harden		Lon	g Jr.			March			004	2007 M
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, o				4c. County		
			Washington Adve			1 4 b * ab 1 b	Tako	oma Par		Dieth	Mont		
	Funeral Director		5. Social Security Number 241-56-6868	6. Sex 1XM 2 F	7. Age (In yrs. 65	Yrs.	Months Days		Min. 8. Date of (Month) July	Day Va	1938	Cour	place (State or Foreign ntry) ington, NC
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	aho	5	Washington DC				n, D.C.						1 ∑Yes 2 ☐ No
	28a-1	ect	10e. Street and Number		1748		10f. Zip Code			10g.	Citizen of W	hal Cour	ntry?
	With Se or		408 Oneida St.	V.E.			20011			Uni	ted S	tate	s America
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Evanting must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced	12. Was Dec	2√DNo ve No		Was Decedent of Hif Yes, specify Cub	lispanic Origin an, Mexican, F	n? (Specify Yes or Puerto Rican, etc.	No-		k, White,	ean India <i>n</i> , etc. lack
9	2 hou	pel	15. Decedent	's Education		16a. Dece	dent's Usual Occup	pation	d working	16b	. Kind of Bu	siness/In	dustry
21215-0036	hin 72	Completed	(Specify only highes	college (	1-4or 5+)	life.	kind of work done DO NOT use retire	d) most o	ir working				
212	filed with Hygiene ither tha	mo.	Elementary/Secondary (0-12)	,		Libra	ry Deck ?						ernment
Pu	e filed al Hygid I other vent, t	Be	17. Father's Name (First, Middle,	Last)				18. Mother's	s Name (First, Mic	idle, Maid	fen Sumam	9)	
<u>a</u>	Ments Ments srked stice	10	Harden Long Sr.					Luna (					
Maryland	2 should be f and Mental h is marked of raumatic eve		19a. Informant's Name/Relations	nip (Type, Print)			ng Address (Street						
	1 and 2 Health tem 27		Ada Long/Wife		001		Oneida Si		Date Date	- 4			
Baltimore,	of H of H if iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from	State 206.	cemetery, cre	sition (Name of matory or other pla			200	Location -	City or To	own, State
Ë	permit. Pages Department of I Important: If its any injury or of once.		' 4 □Donation 5 □ Other (S	oecify)			coln Cem		/22/2004				aryland
3alt	Departitude Depart		21. Signification of Purperal Service	Licensee 6/1/4	1,	F	2. Name and Addre Ort Linco	oss of Facility 101n, Fur	neral Hom	ne .	,	. 1	land 20722
-	40 E = 0		pinan	Z IVNA	<i>1</i> -						ooa,	Mara	Approximate
			23a. Part Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deal each line.	th. Do not en	ter the mode of dyl	ng, such as ca	ardiac or respirato	ry arrest,			Interval Between Onset and Death
10	Physician /Medical Examiner physician up prize prize physician and prize prize physician and prize physician are proposed at the physician are proposed at the physician physician are proposed at the physician physici	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to	(or as a consector as	feilu	re						
. Box 68760,	n certific inding pl use as t	by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1□Live 4□Preg	itcome of pregn birth 2 ☐ Feta nant at time of c	al death 3[	□Ectopic pregnanc	у			23d. Date Mor		ery Day Year
P.0	trthe by th tache	hys	9 Unknown	9□ Unkr	IOWII								
Records, F	w requires that the death been signed by the atte should be detached for		Part II. Other significant condition	ons contributing to c	leath but not res	sulting in the u	inderlying cause gi	ven in Part I.		oid tobaco ☐ Yes		ibute to t 3 □ Prot	he cause of death?
200	w requ	Completed							24a \	Vas an	24b. V	Vere auto	ppsy findings available
Re	e las has	m m							F	utopsy erform <b>ę</b> d	? 8	rior to co leath?	mpletion of cause of
Vital	ician: Th certificate rector, pag	e Co	25. Was case referred to medica					26 Place o	1 ☐ Your Death (Check o		<i>e</i> 1	☐ Yes	2□ No
>	Physician: this certific ral director,	To B	examiner?	Hospital: 1	Inpatient 2	FR/Outpatie	nt 3 DOA Ott	har	ing Home 5□F		6 □Othe	er (Specii	fv)
of	ding After fune		27. Manner of Death  1 Natural 5 Pendir	28a. Dale (Mor	of Injury oth, Day Year)	28b. Time of Injury	of 28c. Inju Wo		28d. Descr		njury occurr		,
Division	or Attending after death. Director: After in by the fune	Certification;	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of Injury - At h ling, etc. (Speci	iome, farm, st fy)	reet, factory, office			on (Street Town, St		er or Rura	al Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 To Certifyii (Check only 2 Medical one)	ng Physician: To th Examiner: On the l	e best of my knoasis of examination	owledge, dea ation and/or in	th occurred at the travestigation, in my	ime, date and opinion, death	place, and due to occurred at the ti	the cause me, date	e(s) and ma and place, a	nner as s and due t	stated. o the cause(s)
	To the within S To the compl	Me	29b. Signature and title of certifie	3/4	Th.	M.P	29c. Licen.	2326	,		Date signed	,	Day, Year)
-	1/		30. Name and address of person	who completed cay	se of death (Ite	1)	Print) 600 Carro	oll Ave	. Tokama				nd
	St Regist	ate rar	31. Date filed (Month, Day, Year,	409	Registrar's Sign								
Di	HMH 17 Rev 1/2	2001			Harry A	ORIGIN	IAL.						

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 03:57 AM Geneva March 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Baynew Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 F 214-16-6472 North Carolina Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 ■ Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5411 Walther Avenue 212:4 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or Itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12. City of Baltimore Custodial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Johnny Redfern Annie Redfern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6238 Radecke Avenue Baltimore, MD 21206 Theodore Redfern/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Mt. Zion Cemetery 3-30-04 \* 4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mylie Funeral Home 638 N.Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complical in sithat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** multisystem organ taylure /Medical Due to (or as a consequence of) **Examiner** b. OVEV Whelming
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physician and a be detached for use as the burial-transit OSEO MYELLA'S

Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ulceration of left heel IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past N months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ , penicardial effusion 1 Tyes 2 No 3 Probably 4 Unknown s certificate has been significater, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Cthen 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 1 Yes 2 No investigation 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD March 23, 2004 Res - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janet Sceffing Johns Hopkins Bayview Medical Center 4940 Easkm Archne Baltimore, MD 21224 Janet Scetting 31. Date filed (Month, Day, Year) MAR 2 5 2004 3 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 09348 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 **Physician** March 20, Virginia Brodus McGehee 12:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore County Towson Gilchrist Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Month Days Hours Min.

April 7,1911 9. Birtholace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖵 F Virginia Yrs. 92 Director 216-52-5095 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or Itams 23a or 28a-f sho The Medical Examinar must be motified at 1 ☐ Yes 2 ☑ No Director Edgemere Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21219 United States 2611 Synder Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3√ Widowed 4 Divorced White Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 Years other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be 1 and 2 should be Health and Mental Myrtle Perry Joseph Rollins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8057 Wallace Road Dundalk, Maryland Daughter nt of Health a Frances Lowery / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. **↓**□Donation 5 □ Other (Specify) 3/23/2004 Baltimore, Maryland Oak Lawn Cemetery 21. Signa by of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Inc. 21222 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heart tar **Physician** non /Medical Due to (or as a consequence of) Examiner Stansais Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and I-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial-Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 ANo
9 Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the o 9 Unknown ed by the been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate . A ( 1 Yes 2 No **Division of Vital** After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hoga Ce 2 1 Yes 2 X No 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funerel Director:, completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 29a. Certifier 1 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier uns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Balto. and Zc 20%

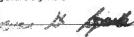
Registrar

DHMH 17 Rev 1/2001

(14 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Bonc



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	1 - For State Registra MEND I	State of M	aryland / Departn <b>c836_10/14/10</b>	nent of Health and cate of Death	Reg. No	).
Physician /Medical	1. Decedent's Name (First, Min	idie, Last)	son, SR		2. Date of Death Month Da	
Examiner Funeral Director	4a. Facility Name (If not institute)  5. Social Security Number  200331350  Usual Residence of Decedent	surre Hospit	Al Central ge (In yrs. last birthday) If I	City, Town, or Location of Dea	8. Date of Birth	BACFEMORE  9. Birthplace (State or Foreig Country)  M
ith the Maryland or 28a-f ehow is notified at	10a. State 10b. Cou	ACTIMERE	10c. City, Town or Location	LRY HALL		10d. Inside City Limit
itter death with the Mar r Iteme 23a or 28a-f el niner man be notified Funeral Director	10e. Street and Number	PER Mill		7. Zip Code 21228	10g. Ci	tizen of What Country? U - S A .
72 hours after death with the Maryla natural; or items 23s or 28s-1 should all Examiner must be notified at leted by Funeral Director	11. Marital Status  1 Never Married 2 Never Married 2 Never Married 2	11 Vas Giva	No Ww 10 Yes	Decedent of Hispanic Origin? (, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "natural, or itemeraumatic event, the Modical Examination.  To Be Completed by Funer	15. Dece	lent's Education hest grade completed)	16a. Decedent's (Give kind life. DO N	Usual Occupation of work done during most of wo OT use retired)  Mechanic	orking 16b. H	Gind of Business/Industry
should be filed vand Mental Hygies marked other tumatic event, to	17. Father's Name (First, Midd	70 11		18. Mother's Na		chown
tem 27	20a. Method of Disposition  4 Donation 5 Othe	on 3 Removal from State	20b. Place of Disposition cemetery, cremator	(Name of y or other place)	Date Balto,	coation - City or Town, Stete
permit. Pages Department of Important: If i any injury or once.	21. Smature Funeral Serv	1 Stills	22. Na 1+ A	me and Address of Facility  They Miller  The FERD  mode of dying, such as cardia	RD. Boito	PRAI HOME CHD.  NO 21234  Approximate
sate be executed by sician and the burial transit the burial transit dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s a consequence of): s a consequence of): s a consequence of):	ilyne		Onset and Death
The law requires that the death certificate to has been signed by the attending physpage 2 should be detached for use as the completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 Ecto	opic pregnancy er (specify)		23d. Date of delivery Month Day Year
n signed by	Part II. Denoi significont con	ditions contributing to death	but not resulting in the under	ying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death? No 3 Probably 4 Unkno
					24a. Was an autopsy performed?	
nysician iis certifii director To Be	25. Was case referred to med examiner?	Hospital:	tient 2 ER/Outpatient 3	Othors	eath (Check only one) Home 5 - Residence	6 □Other (Specify)
ttending death. stor: Afte / the fune  cation	27. Manyer of Death  1 Natural 5 Pe 2 Accident inv 3 Suicide 6 Co	estigation		28c. injury at Work?  1 Yes 2 No	28d. Describe how inju	and Number or Rural Route Number,
		fying Physician: To the bes		curred at the time, date and pla	City or Town, States	s) and manner as stated.
To the Hosp within 24 hours To the Fune completely (III		and manner s		gation, in my opinion, death occurred to the second	29d. D	ate signed (Month, Day, Year)  3/19/04,
State	30. Name and address of per 31. Date filed (Month, Day, Y	ear) 32. Regis	death (Item 23a) (Type, Prin	ten South	Drawin Roll	uniore MOSIZ

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] 09350 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year effrey **Physician** Mc (racken March 21:54 22 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A Himore HO Johns If Under 1 Year If Under 24 Hrs. Kin HOSPITA 6. Sex 8 Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 5. Social Security Number **Funeral** Months Days Hours WISCONSIN 1 M 2 □ F Yrs. 472-84-9399 42 Director 2/19/1962 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23e or 28a-f show Examiner count be notified at MD BALTIMORE OWINGS MILLS 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2024 HUNTING RIDGE DRIVE 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 2 3 Widowed 4 Divorced "naturel" Completed Tie Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) PHOTOGRAPHER SELF EMPLOYED 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be LEONARD P. MCCRACKEN MARGARET T. HEFLIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARGARET T. GANONG MOTHER 44 S. HORSESHORE DRIVE OCEAN VIEW, DE 19970 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 3/25/2004 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part I. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ardiomyo Years resulting in death) /Medical Immunodeficiency Virus **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Ś signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen diopathic Cardiomyopathy 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death unarel Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number March 22, 2004 KES-OW Zadi O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balpmore Maryland Street State

DHMH 17 Rev 1/2001

Registrar

		1	For State Registrar	State of Marylan	d / Depa <i>Cen</i>	rtment of H	lealth and I Death		ene2004	09351
			Decedent's Name (First, Middle, La.	st)			·	2. Date of Death		3. Time of Death
	Physicia	an	PFARI E.V	WEAD				MARCH	Day Year 19 100	7 12:00 A
	/Medic Examin	_	4a. Facility Name (If not institution, giv	e street and number) //		4b. City, Town, or	r Location of Death	1	4c. County of Deat	h
		Ŭ.	CHAPEL HILL 1	UUISING Home	6	KAMPA	Mstown		SALAI	300
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign nuntry)
	Director	d	21120 7725	80	Yrs.			July 11	11930ing	11 pla
	and w	}	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	ation		/		10d. Inside City Limits
	Manyl f sho	0	your long 11	'A	BAlti	LICK				HZVes 2□No
	28e	Director	10e. Street and Number	/ 2	+ 203	10f. Zip Code		10	g. Citizen of What Co	ountry?
	h with	O E	5430 Park He	CIGHTS for		210	0/5		USA	
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-f show he Mudical Evarianer mast be rodified at	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. W	/as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
ထ္ထ	or It	F	1 Never Married 2 Married	1 ☐ Yes 2 No		☐ Yes 2 No	Specify:		Specify	- 06
21215-0036	urel',	d by	3€Widowed 4 □ Divorced	Year or Dates:	16a Deced	ent's Usual Occup	nation	1	6b. Kind of Business	CCC Industry
쟌	n 72	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give I	and of work done	during most of wor			M. Maddiny
12	i withi	Ho	Elementary/Secondary (0-12)	College (1-4or 5+)	EBS1	4 hte	TENSENER		3 ml tiance	City
	e filed I Hyg other	BeC	17. Father's Name (Firsty Middle, Last	)			18. Mother's Nan	ne (First, Middle, M	aiden Sumame)	/
<u>a</u>	uld be Menta rked ric ev	P O	JUHN TO //OW.	Ry			ANNA	ENSTO	er	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "naturel; or Items 23a or 28e-f show or other treumatic event, the Medical Exactinat must be rolliked at		19a. Informant's Name/Relationship (		19b. Mailing	g Address (Street	and Number or Ru	iral Route Number,	City or Town, State,	1.1 1
	of Health of Health item 27 i		EginAld L. Lin	DSAY (50 W)	6/06	sition (Name of	Eperick,	Date / 2	Oc. Location - City or	
Baltimore,	ges 1 t of H If ite or otl		20d. Method of Disposition  12 Burial 2 Cremation 3	Removal from State	emetery, crem	atory or other place	. // / 2	124/11		
ij	permit. Pa Departmen Importent: any injury 20029.		*4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	Ali.	30701	Name and Addre	777	intern	THOTUS	
Bal	permit. Pages 'Department of P Importent: If ite any injury or of		Sa. In	1500		-	is Tersto	- VI	SALTINA	1.4
			24. Pull. Enter the Isease, or com	plications that caused the deat						Approximate Interval Between
	Dhysisian		lmmediate Cause (Final	one cause on each line.	115	HEAD	- FAI	11/11/11	_	Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec	uence of):	VICITO	11/0	Curc	-	75000
н	Examiner		Conventionly liet conditions	B. MITNAL	VALI	EINS	Uffle	ENC	1	20715
-	ש ≡	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uence of):					
	ecute and -trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a consec	mence of).					
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687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	edicai		_ d						
Box (	eath certific attending p for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn.		C-1i			23d. Date of de	livery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Feta 4□Pregnant at time of c 9□Unknown		Ectopic pregnancy Other (specify)	y 		Month	Day Year
P.0	that the deed by the detached	hys	9 🗆 Unknown		-					
	res tha igned be det	by F	Part II. Other significant conditions	contributing to death but not res	sulting in the un	iderlying cause giv 7	ren in Part I.	23e. Did tob	acco use contribute to s 2-⊠No 3 □ Pi	o the cause of death?  robably 4 □Unknown
ord	v requir been si should	ted	1114 30163 MC	1201143) 5	me c			<u> </u>		
ec	elawı hasb ye2st	Completed	HAUGUILLOSI	()10				24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
H		ပ္ပ						1  Yes 2	Ð No 1 ☐ Yes	2 No
Vital Records,	Physicien: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:	150/0	Ott		ath (Check only one		a:(4.)
ō	Phys rthis ral di	۲: ۲:	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	t 3 DOA 28c. Injur	v. 177	28d. Describe ho	nce 6 Other (Spe w injury occurred	City)
on	iding I th. : After funer	ţi	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk?  Yes 2∐No			
Division of	Attendir death.	ifice	3 ☐ Suicide 6 ☐ Could not 1 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (Str. City or Town	eet and Number or R	ural Route Number,
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	Hospitel or Attending 14 hours after death. Funerel Director: After tely filled in by the fune		(Check only 2 Medical Exa	hysician: To the best of my knominer: On the basis of examination	owledge, death ation and/or inv	occurred at the til	me, date and place opinion, death occu	e, and due to the ca urred at the time, da	use(s) and manner as ite and place, and due	s stated. e to the cause(s)
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	one)  29b. Signature and title of certifier	and manner stated.		29c. Licens			d. Date signed (Moni	
	7 wit	-	250. Signature and true or certifier	111		7 49	1390	1	11AMIN 1	3 1×191-
	2		30 Name and address of person who	completed cause of death to	m 23a) (Type,	Print)	10 10	,	1	1,009
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Section   Part	20	nine	Cause (Disease or injury	₹	Due to (or a	s a conseq	uence of:		1 1	, , , , , , ,	1.1		
Section   Part   1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part   1.   Yes   2 No   3   Probably   4   Unk   24a. Was an autoppy ground resulting and proper ground resulting and proper ground resulting in the underlying cause given in Part   23e. Did tobacco use contribute to the cause of death   1   Yes   2 No   3   Probably   4   Unk   24a. Was an autoppy ground resulting and ground resulting and ground resulting and ground resulting and ground resulting and ground resulting ground resulti	n and ial-trans	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b> a.							1,		-
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		•	For State Registrar	State of Marylar		epartment of F Sertificate of I	Death	F	leg. No.	001	
-	Physicia		1. Decedent's Name (First, Middle, Las Charles B.		on,	Sr.		2. Date of Dea Month March	2 <b>2</b> , 2	0 <b>0°4</b> °	3. Time of Death 7:00р м
<b>r</b>	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death			ty of Death	
o a	Funeral Director		5. Social Security Number 6. S 187-12-8866		last birtho	(ay) If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Mar. 3		9. Birth	place (State or Foreign intry) nna
	rland ow		Usuel Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town o	r Location					10d. Inside City Limits
	se-fst	ector	MD Montgom	ery R	ockv	ille			10g. Citizen of	What Co.	1 Yes 2 No
	h with th	ai Dire	10e. Street and Number 11913 Ashley D	rive		10f. Zip Code 2085	52		US		and y r
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28e-f show event, If a Medical Estanicar must be rediffed at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 4 Vidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 数Yes 2 No 19 If Yes, Give Year or Dates:	0.S. 042	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No		pecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ack, White	ican Indian, , etc. White
2-0	"natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. D	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	ation during most of work	king	16b. Kind of I Montq		y County
212	filed withir Hygiene. other then	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		affic Eng	gineer		Gover	nmen	
and	B a b ≥	Be	17. Father's Name (First, Middle, Last) Henry Bentley				18. Mother's Nam Evely	e (First, Middle, n Wirt		ıme)	
Baltimore, Maryland 21215-0036	d 2 s th ar th ar 7 is treu	10	19a. Informant's Name/Relationship ( Robert F. Middle	Type, Print)	19b. N	Mailing Address (Street	and Number or Rui	ral Route Numbe	r, City or Town	n, State, Z	<sup>ip Code)</sup> MD 20910
more,	Page lent o nt: # ry or	ı	20a. Method of Disposition  1 XBurial 2 Cremation 3 C  4 Donation 5 Other (Specification)	jriemovai irom State   💂		isposition (Name of crematory or other place of Heaver		Date ' 0 4	20c. Location	,	own, State ring, MD
Baiti	permit. Departm Importe any inju		21. Signature of Funeral Service-Licer	unlos.			umbia B]	lvd.Sil	ver S	RVIC prin	E,P.A. g,Md20910
3			23a. Part1. Enter the disease, or com shock, or heard ailure. List only Immediate Cause (Final				ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Aspirati Due to (or as a conse	quence of)	:				-	
	Examiner	<u>-</u>	Sequentially list conditions if any leading to immediate	b. Cerebrov		lar accid	dent				
1	rcuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
8768	ificate be executed g physician and as the burial-transit	alEx	resulting in death) Last	Due to (or as a conse	quence or;						
ထ	- m at	Medical	IF FEMALE:								
P.O. Box	To the Hospital or Attanding Physicien: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death	3 Ectopic pregnancy 5 Other (specify)	<i>(</i>			ate of deli	very Day Year
S, D.	res that t signed by be deta	by Ph	Part If. Dther significant conditions	contributing to death but not re	sulting in t	ne underlying cause giv	ren in Part I.				the cause of death?
ord	w require been si	eted	dementia			<u> </u>		1 □ Y	res 2□No		bably 4 Unknown copsy findings available
Rec	The law te has l age 2 s	Completed						autop	rmed?	prior to c death?	ompletion of cause of
/ital	cien: 'ertifica	Be	25. Was case referred to medical examiner?	Hospital:		0th	26. Place of Dea	th (Check only o	ne)		
of	Physi r this c ral dir	7.	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Tir	ne of 28c. Injur	y at	ome 5 Resid			ify)
sion	snding sath. or: Atte	ation	1 ØNatural 5 ☐ Pending 2 ☐ Accident Investigatio		Inji		rk? Yes 2 ☐ No				
Division of Vital Records,	l or Att after de Directe	Certification:	3 Suicide 6 Could not be determined		nome, farn rfy)	n, street, factory, office		28f. Location (S City or Tox	Street and Nun m, State)	nber or Ru	ral Route Number,
	To the Hospital or Attanding Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		nysician: To the best of my kr miner: On the basis of examin and manner stated.							
)	To the within To the comp	Ň	29b. Signature and title of certifies	Q		29c. Licens	058962		3 / 2 4	ed (Month	
	25		30. Name and address of person who Daphna Henkin			ype, Print) field Rd.	Wheaton	n,Md 20	902		
Carried States		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sigr	ature			•			
	Regist	rar	MAR 2	5 2004 Dans	12-6-	& Sp.	acked!	•			

State of Maryland / Department of Health and Mental Hygiene 2004 09354 1 - For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 23, 2004ar **Physician** 4:03a M Munroe Duncan Frank /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 8/27/1922 6. Sex Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 10**X**M 2□ F 81 Yrs. 088-14-8894 New York Director Usual Residence of Decedent with the Maryland 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits 28a-f show 77 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Experiment east be recified at Silver Spring Montgomery MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 804 Dale Drive USA Pages 1 and 2 should be filed within 72 hours after death 1 tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1942
12 Yes 2 No 1945
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Gov't Federal Aviation Executive 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarissa Cooper Walter Munroe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).
804 Dale Drive Silver Spring, MD 20910 19a. Informant's Name/Relationship (Type, Print) David Munroe/Son other 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Beltsville, MD Chesapeake Crem. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3/24/04 permit. Page Department of Important: If any injury or once. 21. Signature of Funeral Service License PHTCTP MORTNALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heaft failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician Septic Shock /Medical Due to (or as a consequence of) **Examiner** C.O.P.D. Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Exan iner Congestive Heart Failure I or Attending Physicien: The law requires that the death certificate beforeculater death.

Director: After this certificate has been signed by the attending physician and in by the Intenest director, page 2 should be detached for use as the burnal-train. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hypothyroidism, dementia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed Parkinson's disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3/23/2004 D45471 30. Name and addr-ss of par on and completed cause of death (Item 23a) (Type, Print) 1111 Spring St. Silver Spring, Md 20910 Yeheyis T.Negussie MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

MAR 2 5 2004

Genera & Sparks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles Motto 04 - 1874State of Maryland / Department of Health and Mental Hygiene AKG Certificate of Death Reg. No. 2001 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2004<sup>Year</sup> March 15, **Physician** Charles Edward Motto /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 102 Kenwood Avenue 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 X M 2 □ F 61 Director 237-40-4328 July 10, 1942 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner number notified at MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 N. Kenwood Avenue or Items 23a 21224 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: white 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 18b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) file clerk nit. Pages 1 and 2 should be filed w artment of Health and Mental Hygles ortant: If item 27 is marked other ti injury or other traumatic event, Ib. social security adm 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be Carmelo Motto Teresa Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael P. Dunn/cousin 2943 Crystal Palace Lane Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page: Department o Important: If 4 □Donation 5 X Other (Specify) in state 21. Signature of Euneral Service Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street naus Baltimore, MD 21201 Pakt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Ur Jorying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical use as t the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. I 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No Completed been 24a. Was an has page

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, certificate this After death. Director: / hours after within 24 hours at To the Funeral D

Approximate Interval Between Onset and Death 23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? 3X Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 X No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 XYes 2 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6XXX ther (Specify) At SCENE Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

3:45 P M

1X Yes 2 □ No

March 16, 2004

111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 17 Rev 1/2001

icisha Greenber 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Rem 23a) (Type, Print)

42. Registrar's Signature

	1	State of Maryland / Department of Health and Men  1- State Registrar  Certificate of Death		ene 2004	09356
Physicia /Medic	al -	1. Decedent's Name (First, Middle, Last), Ruber + LINCOLN MEKAY, Jr.	Date of Death Month	Day Yeer 14 2004	3. Time of Death
Examine Funeral Director	=1	1612 Augus Court Croston	Date of Birth (Month, Day, Y	AA	olace (State or Foreign ntry) UNK
e Maryland la-f show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arundel Crofton			10d. Inside City Limits 1 ☐ Yes 2XINo
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examination that the trivial be trutified at once.	ᆵ	10e. Street and Number  1612 Angus Court  11. Marital Status 1 Never Married 2 Marned Forces? 1 Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No Specify:		USA  14. Race - Amen Black, White,	can Indian, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiene. It a marked other then "natural", or traumatic event, the Medical Expri	Completed by	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	unk 16	Specify: WI	ilte dustry unk
aryland 2. should be filed v and Mental Hygie a marked other t umatic event, in	To Be Co	unk  17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Ro.			unk
Baltimore, Ma permit. Pages 1 and 2 s Department of Health an important: If item 27 Iar any injury or other trau		William Jones MD/DME  20a. Method of Disposition  1  Burial 2  Cremation 3 Removal from State  1  Donation		Oc. Location - City or T	unk
Baltir permit. F Departme Importan any injur		21. Scalure of Eungral Service Licensee 11 tector State Anatomy Board 6. Baltimore, MD 21201	55 W. I	Baltimore S	Street
ds, P.O. Box 68760,  ires that the death certificate be executed  signed by the attending physician and  d be detached for use as the burial-transit  august	licai Examiner	23a. Part   Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or resistance of the property of the mode of dying, such as cardiac or resistance of the mode of dying, such as cardiac or resistance on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Ι,	Approximate Interval Between Onset and Death
I Records, P.O. Box 68  The law requires that the death certifica ale has been signed by the attending ph page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of deliv Month	ery Day Year
cords, P. w requires that I been signed by should be deta			23e. Did toba		pably 4 Unknown
on of Vital Record ding Physician: The taw requir h. Atter this certificate has been si funeral director, page 2 should I	Be Compieted	25. Was case referred to medical 26. Place of Death (Ch	autopsy performe 1 ☐ Yes 2	prior to co death? No 1 Yes	psy findings available mpletion of cause of
on of ding Phy After this funeral d	Certification; To	27. Manner of Death  1 Natural 5 Pending investigation 2 Accident Suicide 4 Homicide   Pending investigation determined   Pending investigation   28a. Date of Injury 2   28b. Time of Injury 2   28b. Time of Injury 3   28c. Injury at Work?   28b. Suicide   28c. Injury at Work?   28c. Suicide   28c. Injury at Work?   28c. Suicide   28c. Injury at Work?   28c. Injury	Describe how	ce 6 Other (Special Injury occurred Self-et and Number or Run State)	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai Ce	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and of examination and/or investigation, in my opinion, death occurred at and manner stated.	due to the cau	se(s) and manner as se and place, and due t	tated. o the cause(s)
To the within To the To the Comp	M	29b. Signature and title of certifier  P. A. M.D.  29c. License number  D. 060574	290	1. Date signed (Month,	Day, Year)
Sta Registr	0.00	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Sones, m.D. 195 America  31. Date filed (Month, Day, Year)  MAR 2 5 2004  MAR 2 5 2004	Con	rt 21	035

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar 09357 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Roy Lewis Newberry, Sr. Month Day March 21, 2004 9:48 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2511 Liberty Parkway Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1½ M 2 □ F Director 219-28-2812 72 Yrs. Nov. 24,1931 South Carolina Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits 17 is marked other than "natural", or Itama 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at Director 1 ☐ Yes 2 🛣 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2511 Liberty Parkway death Funerai 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentai Hygiene. Important: If Item 27 is marked other than "natural", or Item eny injury or other traumatic event, the Medical Emericanone. Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by Specify: 3 Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Steelworker Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Buster Ivy Newberry Alice Perseghin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Roy Newberry, Jr./Son 3013 Dunleer Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3/25/2004 Towson, Maryland 21. Signature of up rai Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 4 7922 Wise Ave. Dundalk Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATTEROSCIEROTTIC CARDIOVASIUZAR DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner Samentially list and tons if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 23e. Did tobacco use contribute to the cause of death? ģ VELGO LIL 54 N DROME Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2☑No 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HORKINS BUYLLAN CV - Balt MD 31274 1105 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State Registrar 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 5:00 AM MARCH D'HEARN /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AUREL If Under 24 Hrs. PRINCE GEORGE MARINER HEALTH OF GREATER LAURE If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□F Months Days 72 014-28-3737 Usual Residence of Decedent Director 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f shov the Madical Examinar must be nutified at 1 Tyes 2 No ARROLLTON Director 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number 20784 EAU 7607 ONTAINE Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 □ No If Yes, Give Year or Dates: 50 - 51 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Il Hygiene. other than TAIL ANTIQUE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any lighty or other traumatic event 2008. Be INKNOWN D' HEARN DAVID ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 080 ANNE CREI AUREL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State REG. 3/19/2001 HANOVER ANATOMY GIFTS 4 Monation 5 ☐ Other (Specify) 21. Signat of Ingral Service Liga 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease or complications to shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Records, P.O. Box 687 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? certificate has been signed by the atte irector, page 2 should be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy 1 ☐ Yes Division of Vital tal or Attending Physician: T s after death. 26. Place of Death Check on one 25. Was case referred to medical examiner? Be Other: wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (*Month*, *Day*, *Year*) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAK PARKHURST NO 5711 SARNS AVE RIVERDALE MD 20737

State Registrar

31. Date filed (Month, Day, Year)

MARK PARKHURST NO

32. Registrar's Signature

	1 - For State Registrar	State of Mar	yland / Department of <i>Certificate o</i>	of Death	Reg. No. 2004	
Physician	1. Decedent's Name (First, Mi	ddle, Last)		2. Date of Month	n Day Year	3. Time of Death
/Medical	Lett	E.	Pyles	MRRC n, or Location of Death	4c. County of Deat	
Examiner	4a. Fecility Name (If not institu	Himory Fan	HASALT /	Baltin	nore NA	
Funeral	5. Social Security Number	6. Sex 7. Age (	In yrs. last birthday) If Under 1 Ye	ar If Under 24 Hrs. 8. Date of	of Birth 9. Birth	hplace (State or Foreign untry)
Director	241-76-5033	181M 2□F	Yrs. Months Day			.C.
pu s	Usual Residence of Decedent 10a, State 10b, Cou		0c. City, Town or Location			10d. Inside City Limits
or 28a-f show	_	,	Baltimore			₩ Yes 2 No
the h	10e. Street and Number		10f, Zip Cod	θ	10g. Citizen of What Co	untry?
3a or	3341 Moravia	Rd.	21	214	USA	
death death	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13. Was Decedent of	of Hispanic Origin? (Specify Yes outland, Mexican, Puerto Rican, etc.	or No- 14. Race - Ame	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show important: if item 27 is marked other then "natural", or items 23a or 28a-f show important printing a source.  To Be Completed by Funeral Director	1 Never Married 2X N 3 Widowed 4 Divor	farned 1 ☐ Yes 2 📉 No				lack
21215-00 ed within 72 had ygiene. her then "natura t, the Medical E	15. Dece	dent's Education ghest grade completed)	16a. Decedent's Usual Oc (Give kind of work do	cupation ne during most of working tired)	16b. Kind of Business/	Industry
athin and and and and and and and and and an	Elementary/Secondary (0-1			tired)	D	
d 212 filed withi Hygiene. other them ent, the M	6th grade  17. Father's Name (First, Midd	tle l'asti	Laborer	18. Mother's Name (First, M	Produce Co	•
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Maryland Ma should be fill the and Mental H 27 is marked out traumatic even To Be	Roosevelt Pyl 19a. Informant's Name/Relati		19b. Mailing Address (Stre	eet and Number or Rural Route N		Tip Code)
Ma alth ar 27 is r trau	Clara L. Pyle	s Wife	3341 Moravi	a Rd., Baltimor	e, Md. 21214	
ore, M	20a. Method of Disposition	on 3 Pemoval from State	20b. Place of Disposition (Name of cemetery, crematory or other)	place) Date	20c. Location - City or	Town, State
Page Page ment of ant: if	'4 □Donation 5 □Othe		Family Plot	3-27-04	Semora, N.	c
Baltimore, permit. Pages 1 a Department of Hes Important: If them any injury or othe suce.	21. Signature of Funeral Serv	ice Licensee	22. Name and Ad	. Bal		21202
ш долая	/lest	That says and the	March F.		E. North Ave.	Approximate
EL LUCIES	shock, or heart failure.	List only one see on each line	ne death. Do not enter the mode of o	dying, such as cardiac or respirat	ory arrest,	Interval Between Onset and Death
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If Records, P.O. Box 68  The law requires that the death certificate has been signed by the attending phyage 2 should be detached for use as the Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			23d. Date of del	ivery
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Records, P.O. The law requires that the law seen signed by the lagge 2 should be detached by Physicampleted by Physicamp	Part II. Other significant con	//	not resulting in the underlying cause	given in Part I. 23e.	Did tobacco use contribute to	1.1
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Vital Relicion: The increase has rector, page				101	Yes 2 No 1 ☐ Yes	21 <b>X</b> No
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Division C tel or Attending P is after death. al Director: Attert ed in by the funera Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	uld not be termined 28e. Place of Injur- building, etc.	y - At home, farm, street, factory, offi (Specify)		tion (Street and Number or Ru or Town, State)	ural Route Number,
Hospital or 44 hours afte Funeral Dir tely filled in				Augustana da da da da da da da da da da da da da		
Divisit  To the Hospital or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1 Cert (Check only 2 Medi	itying Physician: To the best of ical Examiner: On the basis of and manner state	my knowledge, death occurred at the examination and/or investigation, in π ad.	e time, date and place, and due to ny opinion, death occurred at the	o the cause(s) and manner as time, date and place, and due	to the cause(s)
To the within 2 To the complex	29b. Signature and the of cer		29c. Lic	ense number	29d. Date signed (Mont	h, Day, Year)
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10	30. Name and address of per	son who impleted cause of dea	ath (Item 23a) (Type, Print)	ES 000 h Raven Bo	1 ,0	110 10
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		- State Registrar		Ce	rtificate of De	eath		g. No. 20	04 0931
hysiciai	n	Decedent's Name (First, Middle,					<ol><li>Date of Death Month</li></ol>		3. Time of Dear
Medica	al -	CHARLES	Н.	PRE	STON		March		2004 7:50
xamine	er	4a. Facility Name (If not institution, see EDENWALD	give street and number)		4b. City, Town, or Lo			4c. County o	
neral			6. Sex 7. Age (in yrs	s. last birthday)	Tows (		8. Date of Birth	<del></del>	imore
ector		220-18-8462 Usual Residence of Decedent	MA OFF	39 Yrs.		Hours Min	Month, Day, Aug 31,	Year) 1914	9. Birthplace (State or For Country) Maryland
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any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Function Discess	į	MD Bal	timore	Т	owson				1 □ Yes 21⁄2
Email Email	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nat Country?
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E D	iner.	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spec	cify Yes or No-		American Indian,
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othe		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of	Da			ty or Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004

		•	1 - Stata Registrar		Cer	tificate of	Death		Reg. No.		
8	· 100		1. Decedent's Name (First, Middle, Last)					2. Date of De.	ath Day	Year	3. Time of Death
	Physicia /Medic		Mary Ann Par	ks				March	23,	2004	7:30AM M
	Examin	- 4-1	4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town,	or Location of Deat	h		County of Death	
		4	Ruxton Health & Reh							ltimore	
to.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Days		(Month, Da	y, Year)	Col	plece (State or Foreign intry)
	Director		Usual Residence of Decedent	63	115.			June 1,	_1940	)	CT
	and w		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	/anyl	٥	ND 2-1-4		D.:1-	!11-					1 ☐ Yes 2 🎇 No
	28a-	Director	MD Baltimore  10e. Street and Number		Pike	sville 10f. Zip Code			10g. Citiz	en of What Cou	untry?
	with Ba or		303 Sofia Court			2120	10			TICA	
	ns 2%	Funerai		. Was Decedent Ever in U.	S. 13. V	Was Decedent of	Hispanic Origin? (S	pecify Yes or No	- 1	USA 4. Race - Amer	
^	riter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No			oan, Mexican, Puen	to Rican, etc.)		Black, White	, etc.
3	ali, o	by	3√ Widowed 4 Divorced	If Yes, Give 22 Year or Dates:	1	1⊡Yes 2X No	Specify:			Specify: Wh:	ite
21213-0030	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f ahow ent, the Medical Examerar must be motified at	Completed	15. Decedent's Educa (Specify only highest grade	tion	16a. Deced	lent's Usual Occu	pation during most of wo	rkina	16b. Kin	d of Business/l	ndustry
V	thin e	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	ed)	,			
7	ygien ygien t,	Co		4	Nu	rse	1			edical	
and	be fill H d oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,			
y Z	ould Men Marke Marke	2	Alfred Januska				Marcella				
Mary	2 sh and in r	F G	19a. Informant's Name/Relationship (Type	•			t and Number or Ru		-		
ຍ ອ	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, I'm Misdical Exameter must be institled at		Karen L. Strawdern			sition (Name of	Road, Rei	Date		ation - City or T	
5	it of h		1 XBurial 2 ☐ Cremation 3 ☐ Re	moval from State	emetery, cren	natory or other pla				,	
	t. Partmer rtant:		* 4 □ Donation 5 □ Other (Specify)			es Cemet	ery   3/26			sville,	
Baitimor	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other ODES.		21. Signature of Funeral Service Licensee		1			11824 R			
			22a Part Enterthartiseas or complic	ations that caused the deat			eral Home			1, MD 21	.136 Approximate
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final				ing, soon as careia	o o i i o o p ii a i o i y a i			Interval Between Onset and Death
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	/Medical Examiner										
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S.	law requires that the de as been signed by the a 2 should be detached	by P	Part II. Other significant conditions conti	ributing to death but not res	ulting in the ur	nderlying cause g	iven in Part I.				the cause of death?
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ပ္သ	awre is be 2 sho	piet						24a. Was autop		24b. Were aut	opsy findings available ompletion of cause of
ř	0 5 0	Completed						perfo 1 ☐ Yes	2 No	death?	2□ No
Vital Records,	icien: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	ne)		
		2	1 Yes 2 No		ER/Outpatien	T 3 DOA		lome 5 Resid			ify)
0	ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe	now injury	occurred	
DIVISION OF	endi. or: A	cati	2 Accident investigation				Yes 2 No				
Ë	al or Attending Physis after death. I Diractor: After this d in by the funeral di	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stri y)	eet, factory, office	•	28f. Location (S City or Tox		Number or Ru	ral Route Number,
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	To the Hospital within 24 hours of To tha Funeral I completely filled	Medical	(Check only 2 Madical Examine	cian: To the best of my kno er: On the basis of examina	wledge, death tion and/or inv	n occurred at the t vestigation, in my	time, date and place opinion, death occi	a, and due to the urred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	thin 2 tha mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	ise number		29d. Date	signed (Month	, Day, Year)
	W. I		> 13Rejugalisem	2.		n	671115		.3	1231	04
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	l		30. Name and address of person who con		1 53 (Type,	nite 200-	Re isterr	TOWN, 211	136	4	
	Sta	ato	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	1	70,70,3	1			
	Sta	:IG	MAD 9 5 20	04 800	16 1	Erack )					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 23, 2004 7:00a M James Charlie Price, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Baltimore 4102 Edmondson Avenue If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2 ☐ F 217-26-5202 19, 80 Director Nov. 1923 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County "naturai", or itams 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No MD N/A Baltimore Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4102 Edmondson Avenue 21229 U.S.A. Completed by Funeral death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. I finem 27 is marked other than "natural", or flan eny injury or other traumatic event 1 Styles 2 No If Yes, Give 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bethlehem Steel Elementary/Secondary (0-12) 8th College (1-4or 5+) Crain Operator 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Charlie Price, Sr. Susie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ozelia Price - Wife 4102 Edmondson Ave. Balto., MD 21229 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Arbutus Memorial Park 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/27/04 4 Donation 5 Other (Specify) Balto. Co., MD 21. Signal of F 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto., MD 21216 med) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ROSTATE **Physician** YRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death USB 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death ō Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. λq Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 2 No 2 ER/Outpatient 3 DOA this Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident Injury 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 THomicide the Hospital Certifying Physicien To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SORM AUZ 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 5 2004

			For State Registrar	State of Marylan		artment of H			giene , Reg. No. 4	2004	09363
		d-7	Decedent's Name (First, Middle, Last	_				2. Date of De.		Year	3. Time of Death
н	Physicia /Medic		John.	<u>,</u> }	<i>Yuck</i>			MARC	# 2	0 2004	4:55 M
	Examin	er	4a. Facility Name (If not institution, give	1/	4.	4b. City, Town, o	r Location of Deat	1.21		ounty of Death	
			5. Sociel Security Number 6. Se	PKINS 11051 x 7. Age (In yrs.	last hirthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt		NA 9. Birtho	plece (State or Foreign
	Funeral Director		219–50–0808	2 F 55	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da		Cour Md	ntry)
			Usual Residence of Decedent								
	how		10a. State 10b. County		ty, Town or Lo					1	0d. Inside City Limits  1X□ Yes 2 □ No
	Ba-f e	cto	Md. NA	I	Baltimo				40.00	(1111	
	vith th	Director	10e. Street and Number	_		10f, Zip Code	0.7.5			n of What Cour	ntry ?
	s 23s	Funeral	1017 N. Payson S	treet 12. Was Decedent Ever in U	IS 13 1		217 Hispanic Origin? (S	pecify Yes or No		USA . Race - Americ	can Indian.
	item ineri	Fun	11. Marital Status  1 X Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 💢 No		T Yes, specify Cub	an, Mexican, Puen	o Rican, etc.)		Black, White,	
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Maryland 21215-0036	A I A	o Be	John	Ruckei	r, Sr.		Evely			tewart	
Ž	2 should the and Ment is marked aumatic	우	19a. Informant's Name/Relationship (7			ng Address (Street	and Number or Ru				Code)
			Keena Rucker	Daughter	1518	Edison	Highway,	Baltimo	re, M	d. 212	13
altimore,	of He		20a. Method of Disposition  1 🔀 Burial 2 🗌 Cremation 3 🗍		Place of Dispo cemetery, crei	sition (Name of natory or other pla		Date	20c. Loca	ition - City or To	own, Stete
Ĕ	Pages nent of I ant: If its ury or o		° 4 ☐ Donation 5 ☐ Other (Specify		. Zior	Cem.	3-26	5-04	Lans	downe,	Md.
Balt	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra ance.		21. Signature of Funeral Service Licens	588		Name and Addre	-			ore, Md	
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E .	Th ate pag	S						1 ☐ Yes	2 A No	1 Yes	2 No
Zi Zi	Physician: The this certificate har al director, page	Be	25. Was case referred to medical examiner?	Hospital:	ER/Outpatier	the second of	hor	ath (Check only of dome 5 Resi		TOther (Carel	
oţ		To To	1 ☐ Yes 2 ☒ No  27. Manner of Death	28a. Date of Injury	28b. Time o	IL 3 DOA	4 🗆 Hursing r	28d. Describe			<b>y</b> /
on	Attending r death. ector: After by the fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? ]Yes 2∐No				
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	o the vithin o the comple	Med	29b. Signature and title of certifier	and mariner states.		29c. Licen:	se number		29d. Date	signed (Month,	Day, Year)
)	->-0		Deidia C.	Gows M.	Q.	RE	5-00	0	Maxi	ch,20	2004
	M		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)	S-000			,	
			Deidra C. Crew:	5, 600 Nor	th v	volte S	treet, E	aultimon	e Ma	cryland	01 21287
	Sta Regist	ate rar	31. Date filed (Month AR 2) 5	2004 32. Figistrar's Sign	The same	and!					

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Lest) Dav Month **Physician** Ollie William Robinson, Sr. 21, 2004 3:00 PM March /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Deeth Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex 8. Date of Birth (Month, Dey, Year) Funeral Days Hours Months 1 □ XM 2 □ F Yrs. 578-40-4707 70 11, 1933 Wash., Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 10a State r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No 01ney Maryland Montgomery Directo 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number With U.S.A. 16705 Gooseneck Terrace 20832 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. pamit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mantal Hygiane. Important: If Item 27 is marked other than "naturel; or item into injury or other traumatic event, the Maxical Examinary Injury or other traumatic event, the Maxical Examina ☐ Yes 2X No Yes, Give 1 Never Married 2 Married 1□Yes 2ŒNo Baltimore, Maryland 21215-0020 Specify: Specify: Black ò 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Beverage Manager Country Club 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Be James Robinson Alberta Hayden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Ruth Robinson/Wife 1374 W St., NE, Washington, D.C. 20018 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other plece) 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 3-25-2004 Brentwood, Maryland 21. Signatur of Funeral Service Liven ee 22. Name and Address of Facility Fort Lincoln Funeral Home B401 Bladensburg Rd., Brentwood, MD 20722 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Medical Metastatic Lung Cancer Months **Examiner** Due to (or as e consequence of): Physician/Medical Examiner ng physician and as the burial-transit Attending Physician: The law requires that the death certificate be executed Sequentiatty list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, that initiated events Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown Completed by ate has been signe page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 10 Other (Specify)Hospice 1 ☐ Yes 2 🗓 No 3□ DOA Certification: To this 27. Manner of Death 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturat 1 Yes 2 No death. neral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide aftar ò within 24 hours a

To the Funeral C

completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier D42452 March 21, 2004 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Chitra Rajagopal, M.D. 18111 Prince Philip Dr., #327, Olney, MD 20832 31. Date filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

State Registrar

**ORIGINAL** 

32. Registrar's Signature

			1 - For State Registrar	State of Ma		artment of He		Re	g. No. UU4	09365
	Dhomisi		1. Decedent's Name (First, Middle, Last)					<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
	Physicia /Medic		Harry	Samuel_	S	cott		MARCH	23 2000	
>	Examin		4a. Facility Name (If not institution, give :			4b. City, Town, or Lo	ocation of Death	·	4c. County of Dea	ath
	Funeral Director		Upper Chesapeake I 5. Social Security Number 6. Sex	lealth Cen 7. Age	ter (In yrs. last birthday		ir TUnder 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rford nthplace (State or Foreign country)
	Director		155-34-9142 Usual Residence of Decedent		. 39			May 25,	1944   Net	w Jersey
	and w		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	dany f sh	ō	Manyland Haufaud		T7.4	1				1 ☐ Yes 2 No
	the 28a-	ect	Maryland Harford	<u> </u>	Edgewoo	10f. Zip Code		10	g. Citizen of What C	country?
	with	ā								
	s 23	Funeral Director	401 Southridge Con	irt 12. Was Decedent E	ver in IIS 13	Was Decedent of Hisp	) anic Origin? (See	ocifu Vee or No-	II.S. A	<del></del>
	er de	ů,		Amned Forces?		If Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)	Black, Wh	
36	s aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give	9	1 ☐ Yes 2 No	Specity:		Specify:	
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2	Hygie Hygie other	ပိ	17. Father's Name (First, Middle, Last)	5			9 Mother's Name	(First, Middle, M.		unty Schools
Ë	be the day	Be	17. Fallisi Sitallio (First, Micoro, East)			"	D. 1410(110) 3 144(110	[F Wat, Wilder, Wi	andon Gamamo,	
3	should be ind Mental marked o	မ	James	F.	Scott		Dulcie		Long	
Maryland 21215-0036	2 should be and Mental is marked c		19a. Informant's Name/Relationship (Ty			ing Address (Street and				,
~	1 and 2 Health i		Deborah L. Scott (	Wife)	20b. Place of Disp	L Southridg	e Court	Edgewood	Maryland	21040
Ore	ges 1 and 2 should t of Health and Men if item 27 is marks or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ R	temoval from State	cemetery, cri	osition (Name or ematory or other place)	- 1		oc. Location - City o	r Iown, State
E	untment crtant: njury c		* 4 ☐ Donation 5 ☐ Other (Specify)		Bayview	Crematory	3-24	-04 B	altimore,	Maryland
Baltimore,	ornit. Pages of the partment of the partment of the partment. If its only injury or of the partment of the par		21. Signature of Funeral Service License	96		2. Name and Address McCully-Po	Facility	uneral H	lome. P.A.	
<b>m</b>	80.5 8 8		Som F. Gol	line	15.5	3204 Mount				
			23a. Pm1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused	the death. Do not en					Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	1 1	. 1	emorrhage				Onset and Death
	/Medical		resulting in death)	A:	consequence of):	7				70 7001
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	A <sub>k</sub>	Jer	Sequentially list conditions, if any, leading to immediate		consequence of):					,
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Вох	death certifis e attending p ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of					23d. Date of de	elivery
ă	death atte	cia	in the past 12 months? 1 Yes 2 No	1 Live birth 4 Pregnant at t		□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.O.	0 0 2	ysi	9 Unknown	9□ Unknown						
	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions con	ntributing to death bu	t not resulting in the	underlying cause given	in Part I.	23e. Did toba	acco use contribute	to the cause of death?
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360	9 4 9	d E						autopsy	prior to ed2 death?	utopsy findings available completion of cause of
of Vital Record	ician: The l certificate ha ector, page	O						1 ☐ Yes 2	ZfNo 1□Ye	
Z:E	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:	_	Other		(Check only one		
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Ē	ing F	O	27. Manner of Death  → Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 280. Time Injury	Work?		28d. Describe how	v injury occurred	
sio	tend eath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	-			s 2 □No	2011 11 10		
Division	or Attending after death. Director: After in by the fune	Certification:	4 Homicide determined	building, etc	ry - At home, farm, s . (Specify)	treet, factory, office	,	City or Town,	eet and Number or F State)	turai Houte Number,
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	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best on ner: On the basis of and manner star	examination and/or i	th occurred at the time, nvestigation, in my opin	date and place, a lion, death occurre	and due to the cau ed at the time, da	use(s) and manner a te and place, and du	is stated. e to the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier			29c. License n	number	29	d. Date signed (Mor	
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	141		30. Name and address of person who co		ath (Item 23a) (Type	, Print)				
	10.		1 . 4	ctz Vo	Del Ches	apeale Heal	The 1	sel Air	mD 2	1014
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	1.	-	/-		
	Regist		MAR 2 5 2004	Ciemina	10 1	Print) in peaks Head Spacks				

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SLOTT, Harry

State of Maryland / Department of Health and Mental Hygiene 2004 09366 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2004 1:43 MARCH **Physician** William Patrick Spellman, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 24, 1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 82 Yrs. Maryland 212-18-0377 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show s 23a or 28a-f shov XXYes 2□No N/A Baltimore Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21218 3205 Independence Street death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 LANo Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. tems r than "natural", or Items the Medical Examiner m Pages 1 and 2 should be fited within 72 hours after 1 Never Married 2 ☐ Married 1 Yes XX No white Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Maintenance State of Maryland 6th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. Sara Clark William Patrick Spellman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3205 Independence Street Baltimore, MD 21218 Paul Spellman Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 3/24/2004 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura uneral Service Licen e 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) appo ERACERBATION Physician /Medical 10AN Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit or Attanding Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an rmed? 2 Z No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1X Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number AT 2 4 3 8 9 4 6 29b. Signature and title of artifier MATICH 22, 2004 ss of person who completed cause of death (Item 23a) (Type, Print)
PORTOCARCUMO 20/ HMT (MVC) 201 HATT UNIVERSITY PARICUAL/ BOLLMONE, MD 21218 30. Name and address of MIGUET PO 31. Date filed (Month, Day, Year) MAR 2 5 2004 32. Registrar's Signature State Registrar

WILLIAM F.SMITH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 1949State of Maryland / Department of Health and Mental Hygiene DAP For State Registrar Reg. No. 2 0 1 4 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Inney MARCH 19.2004 11:20a NIAM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1 WEST CONWAY STREET APT.813 BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Year **Funeral** 1 2M 2 F 16 231 3 **Director** Maylow Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State 28e-f show ? Is marked other than "natural", or Items 23a or 28e-f shov treumstic avent, the Medical Examinar must be tretified at 115 Yes 2 □ No BAI FOUR Director Mary Ism 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 2120 StrEEt USA UNWON permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "natural", or Items 23a any injury or other treumatin average. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ≅ Yes 2 ☐ No 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify. Yes. Give 3 Widowed 4 Servorced Black Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1214 902018 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 11ionni OCK ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4320 BBIHLE (11 2121) - tame 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition 24/00 1 ☐ Burial 2 ☐ emation 3 ☐ Removal from State BAHANOR \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses REISTERS DUM 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ATMENOSCHEROTIC CANDIOVASCUL **Physician** resutting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, should be 2 X No 3 Probably 4 Unknown 1 🗌 Yes Completed Was an peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed page 2 2 □ No 1 ☐ Yes 20 1 Tes certificate of Vital To the Hospital or Attending Physician: 26. Place of Death | Check only on 25. Was case referred to medical Be niner? Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) AT SCENE XXYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide t 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tle of certifier

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DHMH 17 Rev 1/2001

State Registrar 30. Name and add

31. Date filed

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who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

OCME

MARCH 20,2004

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 2004 09358 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>2004 Month **Physician** March 18, 12:15 P M Richard Wayne Spencer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George Medical Center Cheverly Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

August 3, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F **Funeral** 578-44-3376 67 1936 Wash., D.C. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f ahow Examinar must be notified at 1 XYes 2 No Maryland Prince George Upper Marlboro Direct 10e. Street and Number 10g. Citizen of What Country? 20774 U.S.A. 33 Thurston Drive Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Police Officer Prince George County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Winifred Spencer Verle Elizabeth Kidwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: It isem 27 Is
any injury or other trau Carol Spencer/Wife 33 Thurston Dr., Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Fort Lincoln Crematory 3-19-2004 Brentwood, Maryland 5 Other (Specify) 22. Name and Address of Facility
Fort Lincoln Funeral Home Funeral Service Josense 21. Signature of 3401 Bladensburg Rd., Brentwood, MD 20722 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause opeach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate ! 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation Natural М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Jille of certifier y 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive, Cheverly, MD James Catevenis, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - For State Registrar	State of	Marylan		artment c <i>tificate</i> (			ental Hyg	iene 2 ()	04	09	369
	Physici	20	Decedent's Name (First, Middle, Last)							2. Date of Death		Year	3. Time o	of Death
	Physici /Medio		Paul Smith							3	8	04	345	PM
	Examir	ier	4a. Facility Name (If not institution, give si	reet and numb	Ano R	?		1timo	re		4c. County			
	Funeral Director		5. Social Security Number 6. Sex 120-1568	M 2□F	. Age (In yrs. 75	last birthday) Yrs.	If Under 1 Y Months Da	ear If Uni ays Hou	rs Min.	8. Date of Birth (Month, Day, Apr 26,	<sup>Year)</sup> 1928		place (State htry) York	
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ly. Town or Lo	cation					1	Od. Inside C	City Limits
	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f ehow he Mudical Examiner must be nutified at	tor	MD Tool South		100. 011	Balti						ľ		s 2 No
	ith the or 28;	Oirec	10e. Street and Number				10f. Zip Co	de		10	g. Citizen of	What Coun	itry?	
	ath w	rait	1813 McCulloh Stre					212			USA			
40	fter de	Funeral Director	11. Marital Status 1.  1 ☐ Never Married 2 ☐ Married	2. Was Deced Armed Forc 1 X Yes 2	es?	.S. 13. V	Vas Decedent f Yes, specify	of Hispanic Cuban, Mex	Origin? (Specican, Puerto R	rify Yes or No- lican, etc.)		e - Americ ck, White,		
5-0036	ours att	þ	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Date			Yes 21	No Spec	city:		Specif	blac	ck	
2-6	"naturai",	ietec	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	lent's Usual O kind of work d OO NOT use re	ccupation one during n	nost of workin	g	6b. Kind of B	usiness/Ind	dustry	unk
722	withir liene. r than	Completed	Elementary/Secondary (0-12)	College (1-4	for 5+)	/// // L	truck							
DO	be filed ital Hygi d other	BeC	17. Father's Name (First, Middle, Last)			-		18. Mo	other's Name	(First, Middle, N	laiden Suman	ne)		
y Z	s 1 and 2 should be filed withi f Health and Mental Hygiene. Item 27 is marked other than othar traumatic event, the M	To	James N. Smith							ha A. C				
Mag ( V	d 2 sh th and th is n traun		19a. Informant's Name/Relationship (Typ Zachary Kelly/nep!	-		1	_			Route Number, #D Rose				
Je,	s 1 and 2 of Health item 27 i		20a. Method of Disposition			lace of Disponentery, cren	sition (Name o	of .	Da		Oc. Location			
altimor	Pages ment of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 🖾 Other (Specify)	imoval from St in sta	ale /	,,	,	p.2007	 					
Balt	permit. Pages Department of H Important: If its any injury or of once.		21 Signature Funeral Service Licenses	age, na	Contract 2	St	Name and A ate An ltimor	atomy	Board 21201	655 W.	Baltim	ore S	treet	
			23a. Part1. Enter the disease, or complic spock, or heart failure. List only one	ations that cause on each	used the deat th line.	h. Do not ente	er the mode of	dying, such	as cardiac or	respiratory arre	st,		Approxima Interval Be	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				- CAN	CER	OF L	-ARYN	X	`	Onset and	2 5
78	Examiner			Due to (or	r as a conseq	uence of):								
		ner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying	Chie to (or	as a conseq	meuca ot).								
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	r as a conseq	uence of):						_		
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9	tificate ig phys as the	ledical	0.				55-1							
Š	ath cer tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outco	ome of pregna h 2 ☐ Feta	ancy I death 3 🗆	Ectopic pregn	ancy			23d. Da	e of delive	•	Year
P.O. Box	that the death certificed by the attending postering detached for use as	Completed by Physician/Me	1 Yes 2 No	4□ Pregnar 9□ Unknow	nt at time of d m	eath 5	Other (specify	/)			IVIC	iiui	Day	i eai
ر.	es that gned b	y Ph	Part II. Other significant conditions cont	1	th but not res	ulting in the ur	nderlying cause	given in Pa	urt I.	23e. Did tob	acco use cont	ribute to th	e cause of	death?
Division of Vital Records,	v requires been signi should be	ted t	SMOTHSEM A							1 🗆 Ye	5 2 □ No	3 Prob	abiy 4	Unknown
Sec	e law r has be je 2 sh	mpie			·					24a. Was an autopsy perform	24b.	Vere autor prior to con feath?	psy findings apletion of c	available cause of
<u>a</u>	ysician: The is certificate hadirector, page	e Col	25. Was case referred to medical					00.00		1 Yes 2	⊠(No	Yes	200(No	
\bar{\bar{\bar{\bar{\bar{\bar{\bar{	ysicia is cert directe	0	examiner?	spital:	patient 2	ER/Outpatien	3 DOA			(Check only one e 5 ☐ Resider	-	er (Specify	()	
n 0	tending Physically.  tor: After this the funeral di	on: 1	27. Manner of Death  1 Natural 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		Injury at Work?		3d. Describe how				
isio	ttendir death. stor: Af	icatl	2 Accident investigation 3 Suicide 6 Could not be	29a Plana	f Injuny - At h	ama farm ates		1 ☐ Yes 2		3f. Location (Str.	not and Alumh	os os Ruso	I Clauda Mus	who s
Div	al or A s after il Direct	Certification: To	4 Homicide determined	building	, etc. (Specif	ome, farm, stre	et, ractory, on	ice	20	City or Town,	State)	er or nurar	Houle Nun	nuer,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical (	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina	cian: To the b er: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred at the	ne time, date my opinion, d	and place, ar death occurred	nd due to the car d at the time, da	use(s) and ma te and place,	nner as stand due to	ated. the cause(	s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	1944	N.		29c. Lic	ense numb	91	29	d. Date signe	(Month, L	Day, Year)	
			Miller	M.	0.		Do	058	457	m	ARCH	17	20	04
			30. Name and address of person who con	npleted cause	of death (Item	1 23a) (Type, I	7.1-43			E 708, 1		00-	400	1201
	Sta	te	31. Date filed (Month, Day, Year)	32/Reg	jistrar's Signa	iture	1114	3116	0 31	G108 1	STLLIN	1016-	MI) L	1001
- 8	Registr		MAR 2 5 2004	1300	Marie L	1 had	1							

State of Maryland / Department of Health and Mental Hygiene2001 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year PAUL **SCHUSTER** MARCH 21, 2004 /Medical 4:50 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay Year) FEB. 4, 1912 **Funeral**  Birthplace (State or Foreign Country) 1 M 2 □ F 212-07-8411 92 Yrs. Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23a or 28e-f show the Medical Examinar must be notified at Director MD N/A BALTIMORE 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5607 NARCISSUS AVENUE 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) I Hygiene. other than " College (1-4or 5+) SALESMAN LIQUOR item 27 Is marked other other treumetic event, I 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Menfal Hitant: If item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) Be **JACOB SCHUSTER** LENA HYATT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOY SCHUSTER / DAUGHTER 129 HAWTHORNE AVENUE - PIKESVILLE, MD 21208 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State <u>≒</u> ö permif. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY 3/23/2004 WOODLAWN, MD 21. Signature of Funeral Selvice Licensy 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one caus in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician yocardial disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perform 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Yes No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifie certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marginer stated. one) tle of certifier 29b. Signature as 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Prin 31. Date filed (Month, Day, Year) Registrar's Signature Registrar MAR 2 5 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** JEAN E. TAYLOR MARCH 23, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕏 F Director 212-34-6010 68 1/23/1936 MARYLAND Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at BALTIMORE PARKVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 1813 COBOURG COURT APT. B 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: β Specify: 3 Widowed 4 Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) SALES RETAIL other t 12TH GRADE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, 9002s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ERNEST F. REICHE LOUISE MILBURN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUZANNE TELAK 8426 HARRIS AVENUE DAUGHTER BALTIMORE, MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 3/24/2004 CATONSVILLE, MO
22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myelodysplastic years **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 2 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 No ၉ After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Natural 2 Accident 5 Pending investigation after death.

Director: Aft d in by the fur 1 Tes 2 No 6 ☐ Could not be within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D25205 much 23, 2204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Bulfo. Md 21205 G-BMC 6701 32. Registrar's Signature 31. Date filed MAR 29. 5 2004 State Registrar

3

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** SARA G. VAETH MARCH 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 214-30-3493 Director 3/21/1934 MARYLAND 70 Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD BALTIMORE PARKVILLE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 1302 HILLSWAY COURT 21234 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. ٥ 3 Widowed 4 □ Divorced WHITE "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ( . Pages 1 and 2 should be fill thent of Health and Mental H tent: If Item 27 is marked ott jury or other treumatic even DAVID GILLESPIE FALICE MARKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOWSON, MD 21286 BETHANNE V. LANTGRAFF/DAUGHTER 1533 PROVIDENCE ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Importent: If any Injury or once. METRO CREMATORY, INC. 3/29/2004 CATONSVILLE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SCHEMIC COLITIS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No 21XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Magner of ath 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funerel Direct completely filled in by 4 Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 30263 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 0SL 32 Registrar's Signature FRANCIS KHOO OSLER DRIVE TOWSON, MARYLAND 21204 M. D 31. Date filed (Month Ray Year) 2004 State Registrar

			1 - For State Registrar	State of N	Maryland		rtmen			and M		giene 0	04	09373
	Physici		Decedent's Name (First, Middle, Last	John	Washke	evich					2. Date of Da Month	Day	Yeer	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give				4b. City,		Location o		March	20, 200 4c. Count	of Deeth	
5.	Funeral Director		5. Social Security Number 6. S 216-01-7646	ex 7.7	Age (In yrs. Iasi	t birthday) Yrs.	If Under Months		If Under a		8. Date of Birt (Month, Da April	y, Year)	9. Birth	timore place (State or Foreign ntry) Yland
	ne Maryland 8a-f ehow allfied at	ctor		imore	10c. City, T	fown or Loo				Edge	emere			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the	ai Dire	10e. Street and Number 3120 Sparrows Po	oint Road			10f, Zip	Code	21	219		10g. Citizen of Unite		
920	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f ehow to Medical Examine mast be multical at	by Funeral Director	11. Marital Status  1 Never Married 3 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1 ☐ Yes 2 ⅓ If Yes, Give Year or Dates	nt Ever in U.S. s? ] No		Vas Deced Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	14. Rad Bla Specif	ck, White	can Indian, etc. White
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, It a Medical Examiner man be notified at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12 Years	lucation de completed) College (1-4o		lite. L	ent's Usua kind of wor OO NOT us ip Bu	k done d e retired)	uring most	t of worki	ng	16b. Kind of B		odustry
yland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Mi	To Be C	17. Father's Name (First, Middle, Last) Michael Washkevi						1	Anna	Stasuk	Meiden Sumar	ne)	
	1 and 2 she Health and em 27 is m		19a. Informant's Name/Relationship ( Mr. Donald McCul		son							or, City or Town, YSVille		21030
Baltimore,	Pa in the last		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		e cem	e of Dispos etery, crem ney V	atory or of	her place			ate 3/23/20	20c. Location		
Balt	permit. Pag Department Important: I any injury o once.		21. Signature Funeral Service Licer	C Reed	1			Ruck	Fune	eral		f Dunda Maryla		Inc.
	Physician /Medical	î	23a. Pert1. Enter the disease, or com, shock, or heart divers. List only Immediate Cause (Final disease or condition resulting in death)	a. ACU	ed the death. [line.	Do not ente	or the mode	of dying	such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and strensit transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequent		An	Ter	J.	Di	sease			
O. Box 6	The law requires that the death certificate be executed tite has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2  Fetal de at time of death	ath 3 🗆	Ectopic pre Other (spe						te of delive	ary Day Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death	but not resultin	ng in the un	derlying ca	iuse give	n in Part I.			bacco use cont		ne cause of death?
of Vital Records,		Completed		DEMI DEGNI	ASRATIV	10 c	٦٥١٦	)T	Difes		1 ☐ Yes	med? 2 No	prior to co death?	psy findings available mpletion of cause of
of Vit	Physicien: this certificant	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No		ient 2 ☐ ER/	/Outpatient	3 DO	A Other			(Check only or ne 5 Resid	ne) ence 6 □Oth	er (Specit	y)
Division o	ttending Ph death. stor: After thi the funeral	Certification:	27. Manney of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ay Year)	b. Time of Injury	М		at ? es 2 □ N	No		ow injury occur		18-11
Div	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		4 Homicide determined  29a. Certifier 1 Certifying Ph	building,	njury - At home etc. (Specify)						City or Tow	n, State)		l Route Number,
	To the Hospitel within 24 hours of the Funeral completely filled	ledicai	(Check only 2 Medicel Examone)	iner: On the basis and manner	of examination	and/or inve	estigation,	in my opi	nion, death	h occurre	nd due to the d ad at the time, d	ause(s) and ma late and place,	nner as s and due to	tated. the cause(s)
	with Com	Σ	29b. Signature and title of certifier				29c.	License	number 7148	8	2	3 22		
	5		30. Name and address of person who of Donato Vargas, M.		death (Item 23 ilson E			в м	iddle	Riv	er, Mar	yland	2122	0
ğ	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signature		we!							

		1 - For State Registrar	State of Marylan	d / Depa		Health an	Re	iene <sub>ng. No</sub> 200	4 09374
Physi /Med Exam	dical	1. Decedent's Name (First, Middle, Last)  Ell Sworth Mi  4a. Facility Name (If not institution, give s  Northwest Hospita	street and number)			n, or Location of D	2. Date of Deat Month March Deeth	Day Yea 21, 2004  4c. County of De Baltim	eath 12.13PM
Funera Directo		5. Social Security Number 6. Sex		Vre	If Under 1 Yes	ar If Under 24	Hrs. 8. Date of Birth (Month, Day, 12-28-	Year) 9. E	Birthplace (State or Foreign Country) ARYLAND
th the Maryland or 28a-f show	Director	MD • 10b. County  MD • N/A  10e. Street and Number	В	y, Town or Lo	RE 10f. Zip Code		10	0g. Citizen of What	10d. Inside City Limits 1 ☑ Yes 2 ☐ No Country?
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. If a Medical Examinar must be retilified at	by Funerai [	3405 W. ROGERS AN  11. Marital Status  XXNever Married 2 Married 3 Widowed 4 Divorced	/ L •  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 ¬No If Yes, Give → Year or Dates:	i	2121 Was Decedent of Yes, specify Co	of Hîspanic Origin uban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	USA  14. Race - Ar Black, WI  Specify: B1	
J within 72 hou jiene.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give life. L	tent's Usual Occ kind of work dor OO NOT use ret	ne durina most of	working	16b. Kind of Busines	ss/Industry
rytarru hould be filed d Mental Hyg marked othe matic event,	To Be C	17. Father's Name (First, Middle, Last) HERCULES WILLIAMS 19a. Informant's Name/Relationship (Ty)	3			DELS	Name (First, Middle, M SIE WILLIAM r Rural Route Number,	Maiden Sumame) IS	
Dattilliote, Ma bernit. Pages 1 and 2 s Department of Health ar mportant: If them 27 is mny injury or other trau		RAYMOND BAILEY (NE  20a. Mathod of Disposition  1 Burial 2 Commation 3 R  4 Donation 5 Other (Specify)	EPHEW)  20b. Pemoval from State	34 ( lace of Dispo emetery, cren		OGERS AVI	E. BALTIMOR	MARYLA 20c. Location - City of	AND 21215
permit. Departn Imports any injt	SUCE	21. Signatur Treral Service Lice Service Lic	NATHIN D.	HIBNER 17	Name and Add	ress of Facility I	PHILLIPS FU E ST. BALTI	NERAL HOM MORE, MAR	APPROXIMATE Interval Between
w requires that the death certificate be executed  been signed by the attending physicien and should be detached for use as the burial-transit	ical Examiner	Immediate dause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that intiated events resulting in death) Last	Due to (or as a consequence to (or a))).	uence of):	oato æll	ular o	ancev		Onset and Death
The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1  Live birth 2 Fete 4 Pregnant at time of do 9 Unknown	death 3	Ectopic pregnar Other (specify)			23d. Date of d Month	elivery Day Year
requires that een signed b	þ	Part II. Other significant conditions con	tributing to death but not resi	ulting in the ur	nderlying cause	given in Part I.		acco use contribute	to the cause of death?  Probably 4 Munknown
The lante has	e Completed	25. Was case referred to medical				26 Place of	24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	autopsy findings available o completion of cause of es 2 \sum No
To the Hospitsl or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ertification; To B	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. In	other: 4 🗆 Nursin	g Home 5  Resider 28d. Describe how	nce 6 Other (Sp	ecify)
pitsl or Atte	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	')			City or Town,	State)	Rural Route Number,
To the Hospitsl or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	(Check only 2 Medical Examir one)  29b. Signature and title of certifier	ician: To the best of my kno- ier: On the basis of examinal and manner stated.	ion and/or inv	estigation, in my	opinion, death o	ccurred at the time, dat	te and place, and du d. Date signed (Mor	ne to the cause(s)
3		30. Name and address of person who come Marriay Mejia, MD	mpleted cause of death (Item NC+H+V+C++++10)	23a) (Type, 1	DO ( SAO) OK	d court R	7 Lad Rant	ard 21	1,2009 langland
S Regis	itate strar	31. Date filed (Month, Day, Year)	32. Registrer's Signa	ture	Angela)	,			

			1 - For State Registrar	State of Maryla		artment of He		lental Hygi	ene g. No. 2004	09375
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last)     Alice  4a. Facility Name (If not institution, give s     Continium Care	P. White		4b. City, Town, or L	ocation of Death	2. Date of Death Month March 2	O, 2004  4c. County of Death  Carroll	3. Time of Death 1:15 P M
***	Funeral Director		5. Social Security Number  220-12-7313  Usual Residence of Decedent	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, October	9. Birth 5,1912 V	place (State or Foreign Intry) Inginia
	e Maryland Sa-f show	ctor	10a. State 10b. County MD Carrol		oity, Town or Loykesvil					10d. Inside City Limits 1 ☐ Yes 2 🖁 No
	th with th	Funeral Director	10e. Street and Number 6810 Autumn Dri	ve		10f. Zip Code 21784		10	U.S.A.	intry?
920	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-1 show ha Modical Exemirer must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of Hist f Yes, specify Cuban, I □ Yes 2 No	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	d within 72 ho piene. r than *natur Ine Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired) hone Opera	ring most of work	ing	6b. Kind of Business/Ir	,
Maryland 2	be filed stal Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last) Linwood Pul	ler	retep	-	8. Mother's Name	e (First, Middle, M Alice Be	laiden Sumame)	Broaddus)
	12 shand thand 7 is m traum		19a. Informant's Name/Relationship (Type Alston H. White	<sub>рө, Print)</sub> Husband					City or Town, State, Zi	
Baltimore,	of of		20a. Method of Disposition  XXSurial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, cren	sition (Name of natory or other place) Cemetery		Date 2	oc. Location - City or Toodlawn, MD	own, Stete
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	20nor M603					rs Funeral stown,MD.21	
	Physician /Medical		23a. Pant. Enter the disease, or complies shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the de- le cause on each line.		er the mode of dying,	such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
68760,	Examiner  hysician and  be burial-transit	dicai Examiner	Sequentially list conditions, if any leading to intreclistic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	SI (M)					Yeurs .
O. Box	that the death certifical led by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preging the street of the street at time of the street at time of the street	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
rds, P.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	derlying cause given	in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
al Record	The law ate has b page 2 sl	Completed						24a. Was an autopsy performe 1  Yes 2	prior to co death?	ppsy findings available impletion of cause of
fVital	S S	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No H	ospital: 1 ☐ Inpatient 2[	☐ ER/Outpatien	Other		n <i>Check onli</i> , one me 5 ☐ Residen	ce 6 ☐Other (Specif	ý)
Division of	ding h. After fune		27. Mannar of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work? M 1 \( \text{Ye}		28d. Describe how		
Divis	in Dire	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	etty)			City or Town,		
	To the Hospital within 24 hours a To the Funeral I sompletely filled	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one)	sician: To the best of my kr ler: On the basis of examin and manner stated.	iowledge, death ation and/or inv	occurred at the time, estigation, in my opin	date and place, a lion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner as s e and place, and due to	tated. the cause(s)
	Within To the Comp	Me	29b. Signature and title of certifier	1001 N	11)	29c. License n	3   84	290	1. Date signed (Month,	Day, Year) LOU 4
	r)		30. Name and address of person who con	mpleted cause of death (Ite		BusiNers a	ntr Dri	w fli	Halinn V	mn 21136
χ.	Sta Registr	-	31. Date filed (Month, Day, Year)  MAR 2 5 2004	37 Registrar's Sign	ature	Asa V.				

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Day March 23, 2004 **Physician** Frances Katherine Waterman 3:45 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Augsburg Lutheran Home Lochearn Baltimore 8. Date of Birth (Month, Day, Year)
May 12, 19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 F Months Days 217-07-5853 89 Yrs. Director Massachusetts Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov The Medical Examiner must be notified at Maryland Baltimore Lochearn Funeral Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road 21207 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Slatus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department Store 12th Manager Pages 1 and 2 should be filed v thent of Health and Mental Hygie tant: If item 27 is marked othar I jury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Jones Katherine Grindlay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Eugene Waterman 31 Sheraton Road Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Method of Disposition

1 \( \Delta \) Burial 2 \( \Delta \) Cremation 3 \( \Delta \) Removal from State

Druid Ridge permit. Page Department of important: If eny injury or once. Cemetery March 26, 2004 Pikesville, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD21133-4784 Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE CONCESTIVE HEACT FAILURE 10 man /Medical Examiner DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulling in death) Last TAGE Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physiclan/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 ☐ ₩5 2 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTOD 1 ☐ Yes 2 ☐ No Medical Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural death. 2 Accident 1 □ Yes 2 □ No after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 114593/ 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21208 1200 Park He lus 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 5 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MAR 2004 11:48 AN JAMES WARREN 23 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Arnold Future Care Chesapeake If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 22 1934 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1× M 2□ F Months Hours 69 Yrs. 232-52-9308 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other traumatic event, it is Medical Examiner must be mailthed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23e or 28e-f shov traumatic event, the Medical Exporter must be notified at 1 ☐ Yes 2 ☑ No Pasadena Anne Arundel Directo Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 USA 142 Magothy Beach Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: altimore, Maryland 21215-0020 Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Gypsum Co. Office Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Catherine Spriga Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Baur 2221 Cypress Avenue, Allentown, PA 18103 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 24 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2004 Baltimore, Maryland 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each ling. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical a END STAGE RENAL Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown SEVERE PERIPHERAL VASCULAR DISEASE þ æ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has page 2 2400 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 I Mursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 TYes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospl within 24 hou To the Funer completely fil 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 29c. License number D57531 MARCH 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterans Highway, Nillersville MD 21108 MOHIT NEGI

32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

MAR 2 5 2004

ashing	1- State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death		ne No.2004 1937:
Physician /Medical	Frank Wash	inston		2. Date of Death Month	Day Year 3. Time of Death 2004 1254 p
Examiner	4a. Facility Name (If not institution, giv Sinai Hospital		4b. City, Town, or Location of Dealtimore		4c. County of Death
uneral irector	5. Social Security Number 6. S 216 - 52 - 0580 1 Usuel Residence of Decedent	7. Age (In yrs. last birthda)  7. Age (In yrs. last birthda)  7. Age (In yrs. last birthda)	/) If Under 1 Year If Under 24 Hi Months Days Hours Min		
Sa-f show offling at	10a. State 10b. County	A Balti	ocation MOTE		10d. Inside City Limit 1 ☑ Yes 2 ☐ N
finer must be notified	1602 North Card	line St.	10f. Zip Code 21213	10g.	Citizen of What Country?
Examiner of I by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates;	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
Completed	15. Decedent's Ec (Specify only highest grant Elementary/Secondary (0-12)	College (1-40r5+)	edent's Usual Occupation e kind of work done during most of w DO NDT use retired)	orking 16b.	Kind of Business/Industry
atic event, To Be C	17. Father's Name (First, Middle, Last) Namon Washi	nston	18. Mother's Na	ame (First, Middle, Maid	· ·
any injury or other traumatic event, the Necisal Examiner must be notified at once.  To Be Completed by Funeral Director	19a. Informant's Name/Relationship (1)  Prank Wishington  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specify  21. Signature of Fundam Service Licental)	Removal from State  20b. Place of Disp cemetery, cre King Men	ing Address (Street and Number or F Squimit Ave A socition (Name of matory or other place) corial Park 3/2 2. Name and Address of Facility 1600 Liberty Heim	Date 200.	Location · City or Town, State  odlawn, MD
for use as the burial-transit and property a	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  d	è cardio rasci	leur diste	Onset and Death
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
p p	Part II. Other significant conditions of	intributing to death but not resulting in the u	inderlying cause given in Part I.		use contribute to the cause of death?  2 12 No 3 17 Probably 4 17 Unknown
page 2				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 2 Yes 2 No
this certificate al director, pag To Be Col	25. Was case referred to medical examiner?  127 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	0.4	ath (Check only one) Home 5 Residence	e Dobas (Caralle)
the funer cation:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time o Injury	f 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how inj	
=	4  Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, Sta	
completely fil	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cause( urred at the time, date ar	s) and manner as stated.  nd place, and due to the cause(s)
Comp	29b. Signature and title of certifier  Joshal J	reely MO	29c. License number OCME		ate signed (Month, Day, Year) Ch 24 2004
	Tasha Z Gre			et, Baltimon	re, Maryland 21201
State Registrar	31. Date filed (Month, Day, Year)  MAD 9 5	32: Registrar's Signature	for de		

			1 - For State Registrar	State of Maryland	d / Dep		Health and N	lental Hygi	_	201	09376
	Physic	an	1. Decedent's Name (First, Middle, Last,					2. Date of Death	h	Year	3. Time of Death
	/Medi	cal	Dolan B. Wilbur					March 9			3:30 PM M
1	Exami	ner	4a. Facility Name (If not institution, give 6601 Rapid Wate)				or Location of Death Burnie		4c. County	of Death Arun	do1
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		ace (State or Foreign try)
	Director		216-50-0346 Usual Residence of Decedent	JM 2□F 55	Yrs.	Months Days	Hours Min.	0ct 5, 1	1948	Wash	nington DC
	rylanc		10a. State 10b. County	10c. City	, Town or Lo	cation				16	Od. Inside City Limits
	8a-f	octo	MD Anne Aru	ndel	Gle	n Burnie					1 ☐ Yes 2X No
	with the	Dire	10e. Street and Number 6601 Rapid Water	Wax #102		10f. Zip Code	01060	10	g. Citizen of		try?
	er death with the Marylan Items 23a or 28a-f show	Funeral Director		12. Was Decedent Ever in U.S	3. 13.	Was Decedent of H	21060	acify Yes or No-		SA e - America	an Indian
920	al', or	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1   Yes 2 □ No  If Yes, Give  Year or Dates:		f Yes, specify Cub 1 ☐ Yes 2 🎇 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		ck, White, e	
Maryland 21215-0036	_	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	ing 1	6b. Kind of B	usiness/Ind	ustry
21	D D L	Com	12	College (1-4or 5+)		disa	bled		none		
Ind	0 •	Be	17. Father's Name (First, Middle, Last)	17:11			18. Mother's Name			ne)	
	should bond marked imatic e	10	Robert Isac Nol		405 14-70			Lee Cart			
N S	Ith an 27 is it traus		Betty Jean O'Berry				and Number or Rura 1 Court Gl				
ē,	of Healitem		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of natory or other place			Oc. Location -		
<u>ii</u>	Page ment c ant: if ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  '4 🖾 Donation 5 ☐ Other (Specify)	emoval from State	motory, cros	natory or other plat					
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 Is marked any injury or other traumatic ev <u>once</u> .		21. Stocature of Euneral Service License Ronal S	ade proctor		Name and Addre ate Anat	ssof Facility and MD 2120		Baltimo	re St	reet
	Physician /Medical Examiner	Examiner	23a. Part. Enter the disease, or combinate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	cations that caused the death, le cause on each line.  HYPOXIA  Due to (or as a conseque  Due to (or as a conseque	ence of): BSTR						Approximate Interval Between Onset and Death
. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical Exa	in the past 12 months?	Due to (or as a conseque	cy leath 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliven	y Day Year
P.O.	at the 1 by th etache	Phys	9 Unknown	9□ Unknown							
Records,	w requires the been signed should be de	ted by	Part II. Other significant conditions con HYPERTENS	1	ing in the ur	derlying cause give	en in Part I.	23e. Did toba			cause of death?
l Rec	ysician: The law r is certificate has be director, page 2 sh	Completed						24a. Was an autopsy performe	od? p	Vere autops rior to comp eath?	sy findings available pletion of cause of
Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner?				26. Place of Death				
of	Phys this ral dir	. To	1 ☐ Yes 2 ☑ No ☐ ☐ 27. Manner of Death		P/Outpatient		4 Nursing Hon	ne 5 Residenc			
Division of Vital	ttending Ph Jeath. tor: After th the funeral	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	8b. Time of Injury		Yes 2 □ No	8d. Describe how	injury occurre	ed .	
N N	ital or At	Certif	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)				8f. Location (Stree City or Town, S	State)		
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Phys 2 Medical Examin	ician: To the best of my knowler: On the basis of examinatio and manner stated.	edge, death n and/or inv	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	se(s) and mar and place, a	ner as stat nd due to th	ed. ne cause(s)
	To To 1	Σ	29b. Signature and title of certifier	$\mathcal{N}_{a}$	1	29c. License			. Date signed		
			- Clum S.	Madalary	,MC		0039161	C	03-11	-04	
			30. Name and address of person who con	npleted cause of death (Item) 2		uBurnie,	MD 2106	2			
**	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur		, with	WV 2104				
	Registra	ar	MAR 2 5 200	4 / 1	1 1						

1 Consider Name Park   Masses   Lard   Seed			1 - For State Registrar	State of N	laryland /	Departme Certifica					giene 2	004	09380	
Tourist Services of Control Services of Contro					ast)						2. Date of Dea	ith		
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Solvent Description   Solvent Description	1			4a. Fecility Name (If not institution, gi	ve street and numbe	·)	4b. Ci	y, Town, o	r Location o					3.23 1
Provided by   Provided by				Genesis Heritage	Meridian	Elderca	re ¢tr.		D	undal	k		Baltir	nore
Description of Description (Co. Since Control   District Control   Dis		Funeral				ge (In yrs. last b					Date of Birth	Voor	9. Birth	olece (State or Foreign
100.0 company   100.0 compan	в			218-22-4417	1 □ M 2K35F	75	Yrs. Month	S Days	Hours	Min. J	une $2$	1928		
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Privician   Priv	36	s aft			If Yes, Give		1 ☐ Yes	2[XNo	Specify:			Sp	ecify:	White
Privician   Priv	8	houn	edt				Decedent's Lie	ual Ossus	ation			10) 10:-1		
1	15	in 72	ojet	(Specify only highest gr	ade completed)		(Give kind of v	rork done o	durina most	t of working		16b. Kind (	of Business/In	dustry
1	72	with iene.	mo		College (1-4or	5+)			,			Denai	ctmont	Storo
202. Memoral of Disposition of Dispo	D	Hyg the int,			r)		CTe	K	18. Mothe	er's Name (/	First, Middle, I			profe
202. Memoral of Disposition of Dispo	a	od as b	o B	Lloyd Mockabee									,	
202. Memoral of Disposition of Dispo	ar.	shound M	-	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Addre	ss (Street a					wn. State. Zip	Code)
Contract of the contract of th		nd 2 lith a 27 is r tra		Robert P. Zahner	/ Husban	.d	2609 Ar	bler	Road	Dunc	dalk, M	Maryla	and 21	
Physician Micolical Examinar  Physician Micolical Examinar  Physician Micolical Examinar  To gray a part of the pa	ē,	S 1 a f Hez		20a. Method of Disposition		20b. Place of	of Disposition (A	ame of	-1 1	Date	6	20c. Locati	on - City or To	wn, State
Physician Micolical Examinar  Physician Micolical Examinar  Physician Micolical Examinar  To gray a part of the pa	Ę	Page ent o nt: If ny or	J. A							m. 3/3	24/2004	l Di	ากสิวไห	Marriand
Physician Micolical Examinar  Physician Micolical Examinar  Physician Micolical Examinar  To gray a part of the pa	=	artm ortar injui	1											
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Privisician Microsci acuses (Final Immediate Cause (Final Immediate		TO (1)		23a. Part1. Enter the disease, or con	plications that cause	d the death. Do	not enter the m	W1SE	g, such as	cardiac or re	alk Ma: espiratory arre	ry⊥an ∍st.	a 212.	
Due to (or as a consequence of):   Due to (or as		Dhycisian		Immediate Cause (Final	one cause on each	line.	10-13	v 90			. ,			Interval Between
Sequentially list conditions and continuous form of the past 12 months?    Sequentially list conditions and continuous form of the past 12 months?   Due to (or as a consequence of):   Due to				disease or condition resulting in death)	a. COFO	VAKY K	RIEK	PL	SEASE	<u></u>				
The part of the pa		Examiner			1841	Exper C	- ADD	SU	un Pe	1742				
Due to for as a consequence off:    FEMALE   230. Was decedent pregnant in the past 12 months?   1   24   25   26   26   26   26   27   28   28   28   29   29   29   29   29			Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as				0 10	7				
Section   Sect		uted d ansit	mir	Cause. Enter Underlying Cause (Disease or injury that initiated events	PEZIN	4ERAL	VASO	4111	42	Dro	EASO	E		
FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	ó	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequence	of):					-		
FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	76	ysicie	cai	(	SACK	AL DE	-CUB1	145	ac	CEIZ	)			
9 Unknown  1	9	tifica ig ph as th	edi		-									
9 Unknown  1	ŏ	h cer endir use	N/U				3 OE-4					23d.	Date of delive	ry
The state of the cause of death of the cause		deat	icia		4☐Pregnant a				·				Month	Day Year
The state of the cause of death of the cause	Ö	by the	hys											
The state of the completion of cause of the cause of the completion of cause of the completion of cause of the cause of the completion of cause of the completion of cause of the c			by F	Part II. Other significant conditions	contributing to death	out not resulting i	n the underlying	cause give	n in Part I.		23e. Did tob	acco use c	ontribute to th	e cause of death?
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  21	Ď	en sig	ed	KAEUMBTO	D MX	14 4.17	75				1 ☐ Ye	s 2 No	3 ☐ Proba	ably 4 DUnknown
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  21	Œ	The fi	Eo								perform	18d?	death?	/
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  21	<b>\</b>	ysic is ce direc			Hospital: 1 Inpati	ent 2 ER/Ou	Itpatient 3 0	OA Othe	c _/				Other (Specify	)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature		ital o rs aft al Di led in	Cer			(-,,,					Only or Town.	Cialo		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature		t hour	cai	29a. Certifier 1 Lertifying Ph (Check only 2 Medical Exer	ysician: To the best	of my knowledge	e, death occurre	at the time	e, date and	place, and	due to the ca	use(s) and	manner as sta	ited.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature		the find 2 the find 2 the find 1	ledi		and manner st	ated.	aron invostigatio	1, 111 (11) OP	mon, dean	n occurred a	at the time, da	te and plac	e, and due to	the cause(s)
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	1	7 with	4	29b. Signature and title of certifier	/		29	c. License	number	~	29	d. Date sig	ned (Month, D	Pay, Year)
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	•			Sunse	( / W	2 40	)	02	100			77	404	
		5		30. Name and address of person who	completed cause of	death (Item 23a)	(Type, Print)	01		۸	- 1-	vec		2.2
				Saviuaeik	SURIE	2 4a	kel	Ma	ce s	Men	fælk	14,	0 212	2.22
			17.0	10.00	Little	ars Signature	1.0							

			State of Maryland / Dep	partment of Health and ertificate of Death	, ,		
	- 2		Registrar  1. Decedent's Name (First, Middle, Last)	Timodio or Dodin	Reg. N	· 2004	3. Time of Death
	Physici		WILLIAM HOWARD BONNEY		MARCH 17	, 2004	11:00P <sup>M</sup>
-	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) 36622 JOAN DRIVE	4b. City, Town, or Location of Deal	th 4	c. County of Death	S
1	Funeral Director		5. Social Security Number  207-46-8953  6. Sex 1	/) If Under 1 Year If Under 24 Hrs Months Oays Hours Min		9. Birthplec	e (State or Foreign
	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or 1				1
	show	2		MECHANICSVI	T.LE	100.	. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ecto	MARYLAND ST.MARY'S  10e. Street and Number	10f. Zip Code		itizen of What Country	
	3a or	Ö	36622 JOAN DRIVE	20659	1.5	U.S.A.	•
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Mcdical Examiner must be notified at	Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  12. Was Decedent Ever in U.S. Armed Forces?  ↑□ Yes 2 □ No ARMY  17. Was Decedent Ever in U.S. Armed Forces?  ↑□ Yes 2 □ No ARMY  17. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1  Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Black, White, etc	).
003	ural',	d by	3 Widowed 4 Divorced Year or Dates: 1977-95			WII.	ITE
21215-0036	"nat	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of wo DO NOT use retired)	orking 16b.	Kind of Business/Indus	stry
12	within than the M	шо	Elementary/Secondary (0-12) College (1-4or 5+)	TIRED SGT.	U	.S.ARMY	
	Il Hyg other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maide	- ,	
<u>/lar</u>	should be nd Mental marked o umatic eve	ToE	HARRY R. BONNEY, SR.	MYRTI	E EICHLIN		
Maryland	1 and 2 sho Health and I Iom 27 is me		1 1 1	lling Address (Street and Number or R 2 2 JOAN DR • ME	ural Route Number, City CCHANICSVI		
ïe,	of Hei	1	20a. Method of Disposition 20b. Place of Disposition cometary, or	position (Name of ematory or other place)	Date 20c.	Location - City or Town	n, State
Ĕ	Pages ment of ant: If it ury or o			AN CREMATORY 3-	19-04 ALE	XANDRIA,	VIRGINIA
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		bout one	A YMOND FUNERAL A PLATA MARYLA		P.A.	
H			23a. Part1. Enter the disease, or complications that cause the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardia	c or respiratory arrest,	In	oproximate iterval Between
4	Physician		Immediate Cause (Final disease or condition resulting in death)	malosus		M	nset and Death
,(	/Medical Examiner		Oue to (or as a consequence of):	Panaas			10
		La la	Sequentially list conditions, if any, leading to immediate b. Due t. (or as a consequence of):	anvel			V/
1	ed ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause. Due If (or as a consequence of): cause. Underlying that inflated events				,
ó	cate be executed physician and the burial-transit	Еха	resulting in death) Last  Due to (or as a consequence of):				
8760,	nte be nysicia he bu	dical	d				
ဖ	entifica ing pt e as tl	Med	IF FEMALE:				
Вох	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of delivery Month Da	ay Year
0	he de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			•
۵.	es that tigned by	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the c	cause of death?
Records,	v requires been sign should be				1 🗗 Yes	2 □ No 3 □ Probabi	ly 4 Unknown
00	s been s shoul	Completed			24a. Was an	24b. Were autopsy	y findings available
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Vital	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of De	ath (Check only one)	0 10.03 20	
		70	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing I	Home 5 Tesidence	6 ☐Other (Specify)	
D C	ding Ph n. After th funeral	iio	27. Manner of Death 1 ■Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how inj	ury occurred	
Sic	Attending Phy ir death. ector: After this by the funeral d	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	296 Location (Street	and Number of Guml G	loute Mumber
Division of	ital or Attendins after death ral Director: led in by the	Certification:	determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, ractory, office	City or Town, Sta	and Number or Rural R te)	route Number,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or and manner stated.	ith occurred at the time, date and place investigation, in my opinion, death occurred.	e, and due to the cause( urred at the time, date a	s) and manner as state id place, and due to th	ed. e cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day	y, Year)
7	1		pames t, and still	1064	7 3	>7/8-0	4
	H		30. Name and address of person who completed cause of death (Item 23a) (Type JAMES P. JARBOE, MD 24035 THREE	a, Print) NOTCH RD. HOL	LYWOOD, MD	. 20636	
	Sta Registr		31. Date filed (Month, Day, Year) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	M. South 5			

State of Maryland / Department of Health and Mental Hygienes o o

			Certificate of Death		Reg. No.	4 09382
			Decedent's Neme (First, Middle, Last)	2. Dete of De	eth	3. Time of Death
	Physici /Medic		Earl Douglas Boone	March	$17^{\text{Day}}, 2004^{\text{Ye}}$	10:25 PM
	Examin		4e Fecility Neme (If not institution, give street end number)  4b. City, Town, or Lo		, , , ,	
			20311 Old York Road White F		Balti	
	Funeral Director			8. Date of Birt (Month, De Feb. 6	, 1934 N	Birthplace (Stete or Foreign Country) Orth Carolina
	fand	-	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary	ठ्	MD Baltimore Freeland			1 □ Yes 2 No
	7 28 P	irec	10e. Street end Number 10f. Zip Code		10g. Citizen of Wha	-
	23a Z	ai	1737 Oakland Rd., PO Box 6 21053		U.S.A	
020	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiane. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Merital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Yeer or Dates: Korean	ecify Yes or No- Rican, etc.)	14. Race - A Black, V Specify:	American Indian, White, etc. White
5-0	72 hc	To Be Completed by	15. Decedent's Education (Specity only highest grede completed)  16e. Decedent's Usual Occupation (Give kind of work done during most of workil  If DO NOT use retired)	ing	16b. Kind of Busine	ess/Industry
2	han within	E	Elementery/Secondery (0-12)  College (1-4or 5+)  Carpenter		Ship Bu	ilder
d 2	Hygia ther ont, tr	ပ္		e (First, Middle,	Maiden Surname)	
an	d be antal ced o	O Be	Kenneth Boone Ruth E.	. Mitc	hell	
ary	shoul nd Mi		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rure			
Σ	and 2 alth a 27 is		Norma E. Boone/Wife 1737 Oakland Rd., PO	Вох б		
Baltimore, Maryland 21215-0020	Pagas 1 and of He ant: If Itam		20a. Method of Disposition  1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of Dural Company of other place)  Memorial Gardens  20b. Place of Disposition (Name of Dural Company of Other place)  Memorial Gardens	Date Jarch 22 2004	20c. Location - City Timoni	or Town, State um, MD
Balt	permit. Departimportu		21. Signature of Funeral Service Licensed  22. Name and Address of Facility J.J. Hartenstein 24 Second St., 1	New Fr	eedom, I	nc. PA 17349
			23e. Pert1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	or respiratory ar	rrest,	Approximate Interval Between
	Physician		J V V			Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or <i>co</i> ndition a. End Stage Prostate Cancer M resulting in deeth)	letasta	atic	Yr.
		ē	Due to (or as a consequence of):			Yrs.
1	pen d	edical Examiner	Hypertension  Due to (or as a consequence of):			115.
oʻ	an an rial-tr	Exa	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or as a consequence of):			1
68760,	ifficate a executed g physician and as the ourial-transit	Cal	Ceuse (Disease or injury that initieted events resulting in deeth) Lest  Due to (or es e consequence of):			
80	ath ce ttand or usi	lan/	d			
O	the a	ysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			oute to the cause of death?
٦.	es that tha death cert igned by the attandin be detached for usa	by Physician/N	Diverticulosis	10	Yes 21 No 3	☐ Probably 4 ☐ Unknown
Division of Vital Records, P.O. Box	The law requires that tha death cel ata has been signed by the attandir page 2 should be detached for usa	Completed by	Hyperlipidemia	24a. Wes perfo	an autopsy 2- med?	4b. Were autopsy findings available prior to completion of cause of death?
æ	The la	E		101	res 2 🕅 No	1 ☐ Yes 2X No
Ta	intifica ctor, p	Bec	25. Wes cese referred to medical examiner?	(Check only o	ле)	Daughtort
<u>&gt;</u>	hysic nis ce	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor		dence 6 Other (	Daughter's Specify) Home
ב	ng Pl		1 Naturel 5 Pending (Month, Dey Year) Injury Work?	28d. Describe i	now injury occurred	
<u>s</u>	tendi death. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	28f Location /	Street and Number o	r Rurel Route Number,
$\leq$	or At Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tov		Transfriodis Namber,
_	To the Hospital or Attending Physician: The law require within 24 hours after death.  To the Funeral Director: Atter this certificata has been si complataly filled in by the funaral director, page 2 should	edicai Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and manner stated.			
	o the	Me	29b. Signature and title of postifier 29c. License number		29d. Date signed (M	fonth, Dey, Year)
	⊢ <b>≯</b> ⊢ ö		Vally Rully MP D 54749		3-18-04	
	\$		30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  Allen Reilly, MD, 4805 Bonson Ave., Baltimore	, MD 2	21227	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrer's Signeture			
	Registr	ar	MAR 2 5 2004 Reach 16 Grant 31"			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** February DOROTHY VIOLA BLOCKLINGER 29 2004 00:05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner Chester River Hospital Center Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. Aug 14. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 1 □ M 252 F 83 1920 Pennsylvania 166-18-8470 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Worton Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21678 U.S.A. 25141 Wymont Park Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: ģ 3 to Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail Sales 12 Pages 1 and 2 should be filed vent of Health and Mental Hygie ant: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Isabella J. Unknown Frank L. Baum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25141 Wymont Park Rd. Worton, MD. 21678 Cathy Bitter (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
eny injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/1/04 4 ☐ Donation 5 ☐ Other (Specify) Kent Cremation Smyrna, DE. 21. Signature of Funeral Service License 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech M00510 118 West Cross St. Galena, MD. 21635 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) Autorio Schoratic Cardio Vascular Disano Physician 10 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sovere & Doformities 1 ☐ Yes 22 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 1 Yes 2 No Certification: To 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident neral Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brown St. Chestertown, MD. 21620 199 Stoddard M.D. Neil 31. Date filed (Month, 32. Regi frar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 09384 For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year RYN ELIZABETH MARC 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Days Hours Min. (Month, Day, Year)

December 17, ARROLL ENIZIA 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🛛 F 174-20-3183 79 Director 1924 S. Mountain, PA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at Carroll 1 ☐ Yes 2 No Director Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2221 Gablehammer RD 21157 or Itams 23a LISA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced "natural" Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then, Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic event, ILE M ORCE. College (1-4or 5+) Owner Book store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Jay Webster 2 Marion Matchner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia L. Goodwin daughter 2221 Gablehammer RD Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 XPemoval from State \* 4 ☐Donation 5 ☐ Other (Specify) March 20, 2004 South Mountain, PA Strang,s Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. Lanetti 50 S Broad ST Waynesboro, PA 17268 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PIRATTO Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to to, as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician s the burial Physiclan/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy 1 ☐ Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Certification: To 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ⊡Natural 5 Pending death. 2 Accident investigation 1 Tyes 2 🗆 No the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) Pe 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) TRINA E 5/2-R 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 4

			1 - For Amend Items 23b Registrer 23b	a State of Maryl ,PtII,25 per ME,	and / Dep G829, <i>6</i> 3	artment of H	lealth and M Death		giene Reg. No. 2 (	nni.	00205
	Physici		Decedent's Name (First, Middle, MARGARET ELIZA)	Last)			Doui!	2. Date of Dea Month	ath Day	Year	3. Time of Death
0	/Medic Examir		4a. Facility Name (If not institution, g	ive street and number)	Pines		r Location of Death	Jan	4c. County	004 of Death albot	10:05 PM
	Funeral Director				yrs. last birthday, Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day JULY I 6		9. Birthpl	lace (State or Foreign
	th the Maryland or 28a-f show a notified at	irector	10a. State 10b. County  MD TALBO  10e. Street and Number		City, Town or L	10f. Zip Code			10g. Citizen of V		Od. Inside City Limits Yar 2 No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Examinatination inviting a sone.	by Funeral Director	700 PORT ST., AT  11. Marital Status  1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in Armed Forces?	n U.S. 13.		601 ispanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race Blace Specify	e - America k, White, e	
.d d 21215-0036	filed within 72 ho Hygiene. Ither than *naturent, II'e Medical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, La.	rade completed)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired,	during most of worki		16b. Kind of Bu	OME	ustry
t David	should be find Mental Firmarked of	To Be	JOHN THOMAS GORS	SUCH	19h Maili	og Address (Street a	18. Mother's Name THERESA and Number or Rura	HOFF			
41	Pages 1 and 2 seen of Health arnt if item 27 is		MARGARET A. REEI  20a. Method of Disposition  1   Burial 2 □ Cremation 3	DER/DAUGHTER	N. b. Place of Dispo	1137 WIS sition (Name of natory or other place	HPERING P	INES CT	., KESH	ENA,	WI 54135 vn, State
Margare Baltimore,	permit. P Departme Importan any injuri		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 108 cph →	7	LCO F	. Name and Addres ELLOWS , H	PARK 1-14 s of Facility ELFENBEIN RISON ST	& NEWN	EASTON  AM FUNE	RAL H	
18760,	Physician /Medical Examiner physician and street physician and street street street street street physician and street st	edical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	y one cause on each line.	eath. Do not ent	er the mode of dying	such as cardiac o	respiratory arre-	diovascul	1	Approximate Interval Between Onset and Death 3 Week 30+y=
// .O. Box 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐Live birth 2 ☐F 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	ENTEICATION			of delivery	/ ay Year
Sp.	gne be c	ρ	Part II. Other significant conditions	contributing to death but not r	resulting in the ur	derlying cause giver	n in Part I.				cause of death?
of Vital Records,	The ate has page	Completed	OA, Dapre	rsion	·			24a. Was ar autopsy perform 1 Yes 2	180 / GE	ere autops ior to comp ath?	y findings available pletion of cause of
of Vita	sician certifi rector	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No. 27. Manner of Death		ER/Outpatien	3□ DOA Other	4 Nursing Hom	e 5 🗆 Reside	nce 6 Other		
CDO <del>C</del> Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: Atter this certific completely filled in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not I 4 Homicide determined	90 00 01 11			? es 2 □ No —		w injury occurred eet and Number State)		loute Number,
\$ _	the Hospit hin 24 hours the Funers upletely fille	edicai	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my opin	e, date and place, ar nion, death occurred	nd due to the car d at the time, da	use(s) and mann te and place, an	ner as state d due to th	e cause(s)
	To T To T		29b. Signature and title of Cartifier	enoy	$\sim$	29c. License	Pal6	29	d. Pate signed (	Month, Day	y, Year)
	Stat		30. Name and address of person who Richard A 31. Date filed (Month, Page Year)	ATT CITAL TO		55 ("12 N	nwood 1	Dr. [	asdun	mo	21601
	Registra		JAN 13 2004	March A	Burnet						

State of Maryland / Department of Health and Mental Hygiene 2004 Amended #1,3/2/04, cwc, Kent Co. 1- For State Registra AMEND ITEM #1 PER PHY G829 3/25/04 JG ertificate of Death 1. Decedent's Name (First, Middle, Last) Edith 2. Date of Death Month **Physician** EDNA SMITH DEMPSEY EDITH SMITH DEMPSEY FEBRUARY 24, 2004 4:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1 M 2 TF 96 Yrs. Aug. 215-38-1557 1907 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at 1∏Yes 2∏No Director Queen Anne's Centreville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö , or Itame 23a 21617 USA 205 Armstrong Street death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Specify: White þ 3 ₩idowed 4 Divorced "naturel", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Il Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) 11 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any light of other traumatic event poice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Edward Smith Sarah Gertrude Newsome 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Wave Court Salen, S.C. 29676 <u>Doris Smith Hartman</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/26/2004 Chestertown, Maryland Chester Cenetery \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral 130 Speer Road Chestertown, Maryland Kick Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year detached for Month 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown o 9 Unknown s been signed by the should be detach Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ ★o 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 🗆 No 1 TYes 1 Yes 2**>**No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 ☐ No ို Nursing Home 5 Residence 6 Other (Specify) this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending ours after death.
neral Director: A
filled in by the fu death. investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) o the 29b. Signaturand title of certifier 1)37036 who completed cause of death (Item 23a) (Type, Print) 30. Name and address Donals D-in Clash, MS 21619 e 2108 A. 000 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For Amend Items 25,27 Registrar	State of Maryland / De ,28a-fper ME,G829,03	epartment of Health and Certificate of Death	I Mental Hygid	2004	09387
	Physici	an	1. Decedent's Name (First, Middle, Last)  William H. T	Fletcher		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give		4b. City, Town, or Location of De	ath O I	4c. County of Death	8,03,
	Examin	er		aryland	Battimore		NIA	
	Funeral Director		5. Social Security Number 6. Sec. 2/8-20-5/54	7. Age (In yrs. last birthe	Months Davs Hours Mi		(ear) Coul	plece (State or Foreign htry)
	and wo		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	or Location		<u></u>	10d. Inside City Limits
	Mary Ind	tor	Maryland Queen	Annes Qu	Leenstown			1 ☐ Yes 2 🗷 No
	or 284	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Cou	ntry?
	s 23e	erail	109 Scott to	Un Road  12. Was Decedent Ever in U.S.	2/658 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Americ	can Indian
S	riter d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 ØYes 2 □ No If Yes, Give	If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White,	
003	urel', c	d by	3 2 Widowed 4 □ Divorced	Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: B	lack
215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f ehow ta Medical Examiner mind be codified at	ojete	15. Decedent's Edu (Specify only highest grade	e completed) (6	Decedent's Usual Occupation Give kind of work done during most of w life. DO NOT use retired)		6b. Kind of Business/In	dustry
212	d with giene. or than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	reman		B+S F	ishery's
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Item 27 Is marked other than "naturel; or Items 23s or 28s-f show any injury or other treumatic event, the Medical Examiner must be collised at ODGs.	Be	17. Father's Name (First, Middle, Last)	-1 1 1	18. Mother's N	lame (First, Middle, Ma	uiden Surname)	/
Maryland	should and Mer Is marke	2	19a. Informant's Name/Relationship (Ty	o Fletcher 196. N	Mailing Address (Street and Number or	-C. N Rural Route Number, (	City or Town, State, Zip	Code)
	and 2 s leaith ar m 27 is her treu		Debra Acoff	/ Care Giver 10			stown, M	NO 25 0 12
ore,	of He of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of D			c. Location - Tty or To	own, State
Baltimore,	permit. Pages Department of Important: If It any injury or o		*4 □Donation 5 □ Other (Specify)	Md. Ve		los 2001 1	Hurlock, M	unry land
Bal	Department Department		21. Signature of Funeral Service Licens	TOLO	Page 24 Address of Facility Bennie Smith Fur 426 Dover Stree		Maryland 21	601
H			shock, or heart failure. List only or	ne cause on each line.	et enter the mode of dying, such as card			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of)	hemotoma S	timday-	tofall	24 Hours
	Examiner			Due to (or as a consequence or,	<i>j.</i>	111		
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	and and il-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)	):	ORY ME CHEXAMINE	R	
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Box	that the death certificed by the attending prodetached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delive Month	ery Day Year
0	the de yy the a ached f	nysic	1 ☐ Yes 2 🖄 No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 ☐ Other (specify)			
<u>α</u>	requires that een signed b nould be deta	by Pt	Part II. Other significant conditions con	ntributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did toba	cco use contribute to the	he cause of death?
Vital Records,	v require been sig should b					1 🗆 Yes	2 No 3 Prot	Dably 4 Unknown
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lal		e Co	25. Was case referred to medical		26 Place of F	1 Yes 20		2D No
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Ω	al or A s after il Dire	Certif	4 Homicide determined	building, etc. (Specify)	s Center Parking Lot	City or Town,	Street, Chest	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (			death occurred at the time, date and pla for investigation, in my opinion, death oc	ice, and due to the cau	se(s) and manner as s	tated.
	Vithin 2	Med	29b. Signature and title of certifier		29c. License number		I. Date signed (Month,	
	. 2,20		K. Galla	Mu, mD	P1651	16	01/27/04	
			30. Name and address of person who	pleted cause of death (Item 23a) (T	P1652 ype, Print) 22 South Green	Show	+ p	21201
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	LL SOWN Green	re sive	bath	ore MD
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State of Mar	yland / Department of Health and I	Mental Hydlene
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Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Physician 6:34р. м Marjorie Thompson Fry February 23, /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecilton
f Under 1 Year If Under 24 Hrs. In Indian 5224 Augustine Herman Highway Cecil 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2₩F Months Director <u>212-50-7158</u> 75 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location r then "natural", or Items 23a or 28a-f show the Medical Exand sermas be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Direct Maryland CEcil **CEcilton** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5224 Augustine Herman Highway 21913 death USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be fited within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No þ 3√ Widowed 4 Divorced Specify: Specify: White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ind Mental Hygiene.
I marked other then umatic event, it a Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental Maurice L. Thompson Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 Elizabeth Fry Powell/Daughter 5224 Augustine Herman Hwy, PO BOX 33, Cecilton, MD Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Important: If any injury or Chesapeake Cremation Center 2/27/2004 Stevensville, Maryland 21. Signature Funeral Service L permit. 22. Name and Address of Facility Fellows, Helferbein & Newnam Funeral Home, P.A. llows ic 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Metastano Carcinoid Syndrone resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 Yes 25 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: after death.

Director: After this certific
I in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056327 2124104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tool West High St. Suite 312 EIKton ND 2192 Cydney YW 31. Date filed (Month, Day X strar's Signature State Registrar

			1 - For State Registrar	State of Ma	ryland	d / Depa <i>Cei</i>	artmer <i>tifica</i> i	nt of H te of L	ealth a Death	and M	lental Hy	giene 2	004	093	389
<b>.</b>	Physici /Medio			aye	G	iles					2. Date of De Mar 20	2004	Year	3. Time of 7:50pm	
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	Funeral Director		5. Social Security Number 6. Sept 1 Security Number 1 Security Num		(In yrs. Ia	ast birthday) Yrs.	Months	r 1 Year Days	If Under: Hours	Min.	8. Date of Birt (Month 3 1	, 1962	9. Birth	nplace (State of	r Foreign
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920	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Macdical Experiment maintible modified at ance.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 Xo If Yes, Give Year or Dates:		- 1	Was Dece f Yes, spe	Y	spanic Orig n, Mexican Specify:	gin? (Spo i, Puerto	ecify Yes or No- Rican, etc.)		ace - Amer ack, White ify: Wh		
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Baltimore,	Peges 1 and of He out: If Itam		20a. Method of Disposition  1  Burial 2  Cremation 3  R  4 Donation 5 Other (Specify)	emoval from State	Sca	ace of Dispo metery cren Irpelli Fu	sition (Na natory or Ineral	me of other place Home	PA		3/22/2004	20c. Location			MD
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Divisi	Ditte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At hon (Specify)	ne, farm, stre	et, factor	y, office		2	28f. Location (S City or Tow		ber or Run	al Route Numb	er,
	4 to 4 to 4 to 5 to 5 to 5 to 5 to 5 to	edical C	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	sician: To the best of ner: On the basis of eand manner state	xamination	rledge, death on and/or inv	occurred estigation	at the time, in my op	e, date and inion, deat	d place, a	and due to the co	ause(s) and m late and place,	anner as s	stated. o the cause(s)	
)	To the within 2 To the Complet	Me	29b. Signature and title of certifier	1 /				. License D	number 0915	7	2	3-2			
	3		30. Name and address of perso who co Paul Snow M.D.	277			Print)	24 V	/. 3rd	Stre	et Cuml				
E	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	s Signati		10	Rose	A. 57 -	~					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

RPD			1 - For Amend & Registrar	Unpend Item	#4b,23	a,26	artment of the Cifficate of	Death and I	Mental Hy 14	giene Reg. No	2004	09390
	Physici	an	1. Decedent's Name (First, M Burton I		stings				2. Date of De Month March		2004 <sup>Yeer</sup>	3. Time of Death 0324 P M
	/Medic Examir		4a. Fecility Name (If not instit	ution, give street and nu			4b. City, Town,	or Location of Death		4c.	County of Deeth	1
001	Funeral		309 Oakley S 5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Yea Months Days	r If Under 24 Hrs.	8 Date of Bi	rth	orcheste	Nace (State or Foreign
B	Director		216-54-9642 Usuel Residence of Deceden	15€M 2□F	54	Yrs.			Dec. 2	24, 1	949 Mar	ýland
-	ed al	à	10a. State 10b. Con	orchester	10c. City	, Town or Lo		ridge			1	0d. Inside City Limits 1 XYes 2 No
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Baltimore,	·		20a. Method of Disposition  1 ABurial 2 Cremat  4 Donation 5 Other		State C6	emetery, crer	sition (Name of matory or other pa Memoria		Date 3/11/04		cation - City or To bridge,	
Balti	permit. Page Department of Importent: If any injury or		21. Signature of Funeral Ser	vice Licensee				ress of Facility Tr t St., Can			1 Home P 21613	.A.
			23a. Part1. Enter the disease shock, or heart failure.	e, or complications that clist only one cause on	caused the death	. Do not ent	er the mode of d	ying, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		eroscle		Cardiova	scular Di	sease			
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequ	ience of):						
	xecuted and al-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consequ	ience of);	d style.					
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ds, P.O	uires that the signed by d be detact	by	Part II. Other significant con	iditions contributing to c	leath but not resu	ilting in the u	nderlying cause o	given in Part I.			\	ne cause of death?
Division of Vital Records,	The law requir	Completed							24a. Was		24b. Were auto prior to co death?	psy findings available mpletion of cause of
/ital	siclan: Th certificate rector, pag	Be	25. Was case referred to me examiner?	Hospital				26. Place of Dea	ith (Check only	one)		
on of	ding Physician: th. : After this certific funeral director,	tion: To	1 XYes 2 No  27. Manner of Death 1 Natural 5 Pe 2 Accident inv	28a. Date		ER/Outpatier 28b. Time o Injury	28c. In	4 🗆 Nursing n	ome 5 Res 28d. Describe			At Scene
Divisi	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ Co	ould not be stermined 28e. Place build	e of Injury - At ho ling, etc. (Specify	me, farm, str	eet, factory, offic	8		(Street and own, State)	d Number or Rura )	I Route Number,
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	To th To th comp	Me	29b. Signature and title of ce	Wier /	10			nse number		29d. Date	e signed (Month,	Dey, Year)
			30. Name and address of pe	rson who completed cau	se of death (Item	23a) (Type.	O.C.	M.E.		Marc	ch 8, 200	)4
_			S. R. 140	gert			111 Penr	Street,	Baltimo	re, M	Maryland	21201
	St Regist	ate rar	31. Date filed (Month, Day,	MAR 1 0 200	Registra Signal	S &	food					

			i icusc	State of Ma	nyland /	Denartm	ent of H	ealth and	Mental Hy	raiene	Legibie.	
			1 - For State Registrar	State of Ivia	arytaria /	Certific			·····	Reg. No	711111	09391
	Physici	an	1. Decedent's Name (First, Middle, Las	(st)	1/ 1/	0			2. Date of De Month	ath Da	/ Year	3. Time of Death
	/Medic	al	4e. Facility Name (If not institution, give	e street and number)	Hubb		ity Town or	Location of Dea	03	40	County of Deet	7 /M
	Examin	er	Unionity	of Man	land		Bal	tinon	14 4 1/1		Ba	throse
	Funeral Director		48295773	ex 7. Age ☐ M 2 ☐ F	83	birthday) If Un Monti	der 1 Year ns Days	Hours Min			9. Birti Co Ma 1	hplace (State or Foreign untry) ryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Location						10d. Inside City Limits
	e Mary	ctor	MD Kent		Rock	Hall						1 ☐ Yes 2 X No
	with th	Funeral Director	10e. Street and Number 21930 Harring	ton Dawle	Dα		Zip Code 21661				izen of What Co	untry?
	ns 23	eral	11. Marital Status	12. Was Decedent I					(Specify Yes or No orto Rican, etc.)		5 • A • 14. Race - Ame	
)	72 hours after death with the Maryland natural; or Items 23s or 28s-f show deat Examirser must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 N If Yes, Give Year or Oates:	lo		pecify Cubar		erto Rican, etc.)		Black, White	hite
2000		Completed	15. Decedent's Ec (Specify only highest gra		16	Sa. Decedent's U	Isual Occupa work done d	tion uring most of w	orking		nd of Business/ alth	Industry
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	2 m m 2		19a. Informant's Name/Relationship (									<i>tip Code</i> ) 21661 ck Hall M
	s 1 and 3 f Health Item 27 other tr		20a. Method of Disposition		20b. Place	of Disposition (i	Name of		Date		cation - City or	
	0 0 = =		1  Burial 2  Cremation 3  C  1  Other (Specification 5  Other (Specification 5  Other)			ey Cha			/21/04	Roc	k Hall	, MD.
	permit. Pag Department Important: I any Injury o Q0C8.		21. Signatura - Foren I Service 1.51	M	00510	118	west	cross	St. Ga.	Lena	ephen MD.	L Schaech 21635
			23a. Part1. Enter the disease, or com shook, or heart ailure. List only	plications that caused one cause on each lin	the death. D	o not enter the n	node of dying	, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as:		genic	71	ock				12 hrs
	Examiner		ez-construire de la financia	Due to (or as	a consequence	-51	Ant	en s	Diseas	se		
1	D 4	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	consequenc	e o :						
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	e ys	cal		. d	,	,						
2	leath certificat attending phy I for use as the	/Med	IF FEMALE:	23c. If yes, outcome	of preopency							
	0 0 0	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 4 Pregnant at	2 Fetal dea	th 3□Ectopic 5□ Other	pregnancy (specify)				23d. Date of deli Month	very Day Year
	The law requires that the ite has been signed by th vage 2 should be detache	by Pr	Part II. Other significant conditions of	ontributing to death bu	ıt not resulting	in the underlyin	g cause give	n in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
	w require been sig should b								10'	Yes 2	⊠No 3∏Pro	bably 4 Unknown
	e faw r has be je 2 sh	Completed							24a. Was autop		24b. Were aut prior to c death?	topsy findings available ompletion of cause of
			os W						1 ☐ Yes	2 🗷 No		2 🗆 No
	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/O	Outpatient 3	Otho	-	eath <i>(Check only o</i> Home 5 ☐ Resid		S □Other (Soec	ifv)
	ding Phy h. After thi funeral o	Ju: T	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injur (Month, Day	y 28b	. Time of Injury	28c. Injury Work		28d. Describe I			,,
	ten leat lor; the	catle	2 Accident investigation 3 Suicide 6 Could not be			М		es 2 □ No	006 1	24	111	- I Marsha Marsha
	o # ¥ c	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	iry - At nome, :. (Specify)	farm, street, fac	tory, office		City or Tov			ral Route Number,
	To the Hospital within 24 hours a To the Funeral i completely filled	edical	29a. Certifier (Check only one)	ysician: To the best of niner: On the basis of and manner sta	examination a	ge, death occurr and/or investigat	ed at the time ion, in my op	e, date and place nion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of fertifier				29c. License		1		e signed (Month	* * * * * * * * * * * * * * * * * * * *
	6	-	· W/VIL				P17	100		0.	3 17	40
(	7	1	30. Name in address of pitton who	completed cause of de	eath (Item 23a		ndia	· Su	us. V	m	217 m5	
D.	Sta	te	31. Date filed (Month, Day, Year)		r's Signature			¥				
15	Penietr	25		3. 7HHB//	·	20 1	3.0 23	· ·				

		_	For State Registrar	State of	Marylan		artment of I		Mental Hy	giene Reg. No. 2 (	004	09392
	Physicia	0.0	1. Decedent's Name (First, Middle, La Frank Edward Jac	-					2. Date of De Month Feb.	Day 29,20	Year	3. Time of Death
	/Medica Examine		4a. Fecility Name (If not institution, gin	ve street and num		1		or Location of Dea Easton		4c. Count		
**	Funeral Director		215-38-0905	Sex X□M 2□F	7. Age (In yrs. I 98	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ly, Year) 906	Cour	place (State or Foreign htry) Land
	Maryland I show	.	Usual Residence of Decedent 10a. State 10b. County  Maryland Talbot			, Town or Lo	ocation			-	1	0d. Inside City Limits
	with the	Direc	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mardinal Examinar must be notified a page.	by Funeral Director	29313 Corbin Par  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced		2 XNo		Was Decedent of I If Yes, specify Cub	601 Hispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Į.	ce - Americ ick, White, fy: Whit	etc.
Jackson Maryland 21215-0036	within 72 hc ene. than "natur he Wedical	Completed by	15. Decedent's E (Specify only highest gi		-4or 5+)	(Give life.	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of B		
ackson aryland 2	uid be filed fental Hygic rked other tic event,	To Be Co	6 17. Father's Name (First, Middle, Las William Edward J			Fan	ming		me (First, Middle beth R.			
lac.	2 should and Men is marke raumatic		19a. Informant's Name/Relationship			1	ng Address (Street				, State, Zip	Code)
Frank Jaltimore, M	ages 1 and nt of Health : if item 27 ror other tr		20a. Method of Disposition 1   Burial 2 □ Cremation 3 [		Statter (	lace of Dispo emetery, crea	3 Corbin stion (Name of matory or other pla	ce)	Date	20c. Location		
Fra Baltin	permit. P. Departme Important any injury 2002		4 Donation 5 □ Other (Special Signature) Funeral Service Lice	nsee		Fe	lle Cemet Name and Addre ellows, F	ess of Facility lelfenbei	n & Newr	am Fune	ral H	e, Maryland Iome, P.A. 21651
8760,		licai Examiner	23a. Part1. Enter(the disease, or corshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a.  Due to (c	espiro or a a consequ	uenos of): 2 u mo	foilure		c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	he Hospi in 24 hour he Funer pletely fill	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the miner: On the ba and mann	sis of examinat	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	me, date and plac ppinion, death occ	e, and due to the urred at the time,	cause(s) and made and place,	anner as st and due to	ated. the cause(s)
	To t To t com	Σ	29b. Signature and title of certifier	Horou.	Laura -	Jin	29c. Licen:	55484		29d. Date signe	d (Month,	4
			30. Name and address of person who Haiou Laura Jin,	completed cause	e of death (Item	23a) (Type,		ston Mar	rland 21	501		
į,	State Registra	_	31. Date filed (Month, Day, Year)		egistrar's Signa	ture		Scorr Par	Y LOUIN ZI	J. J. T. T. T. T. T. T. T. T. T. T. T. T. T.		

State of Maryland / Department of Health and Mental Hygiene 2004 09393 Amend Items 28e, fper ME, G829, 03/20/04dhb Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 2004 3:15AM MARCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give stre end number) Examiner NIA MediCAL BALTIMURE to R If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 9. Birthplace (State or Foreign Gountry) MARYLAND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 MM 2 □ F 12-12-5538 Yrs Director Usual Residence of Decedent 10d. Inside City Limits Peges 1 end 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State HARFORD 1 ☐ Yes 2 ☑ No MARYLAND Director BERDEEN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code SA ROAD TEPNET 21001 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 A Yes 2 □ No If Yes, Give 1 ☐ Yes 2 K No Specify. Baltimore, Maryland 21215-0020 Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TUTOMATIC 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be KALMBACHER MARY KIETHLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 Is other traus N. STEPNEY ROAD KALMBACHER ARERDEEN MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition MARIE H 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4,2004 BEL AIR FOREST HILL 4 ☐ Donation 5 ☐ Other (Specify) FUNERAL CHAPTE- BEZAIR 22. Name and Address of Facility EVANS 21. Signature of Funeral Service Lisensee DRIVE, FOREST HILL, MD 21050 NONPORT 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician FAILURE Immediate Cause (Final disease or condition resulting in death) /Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician/Medical Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. Completed by 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 D es 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpetient 3 DOA : After this funeral o 28a. Date of Injury (Month, Day Year 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred edical Certification: Injury 1 □ Natural 2 ☑ Accident 5 Pending Patient FeLL 1 ☐ Yes 2 ☑ No -2004 death. A Director: A investigation UNKNOWN 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1208 Stepney Road, Aberdeen, MD 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Home within 24 hours a

To the Funeral D

completely filled To the Hospital 29a. Certifier 😥 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 7667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10NG-Reenc Street Baltimure MD 21201 toshio - Noue, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 2 0 2004 Registrar

DHMH 16 Rev 6/95

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Physicia	ın	Decedent's Name (First, Middle, Last     ODETER:		C					2. Date of Deat Month	Dav	Year	3. Time of Death
/Medic	al .	GRETEL	MICHAELI	2	4h Cih	, Town or	Location o	f Death	JANUARY	7	of Deeth	1:00 A N
Examin	er	ta. Fecility Name (If not institution, give SUBURBAN HOS			1	ETHES		Joann			GOMER	Y
Funeral		5. Social Security Number 6. Se		In yrs. last birthday		er 1 Year	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day,			place (State or Foreig
Director		579-42-1018	□M 2 <b>X</b> F	90 Yrs.	Mornins	Days	Tiodis	14141.	DEC. 9,	1913	GE	RMANY
š	}	Usuel Residence of Decedent  10a, State 10b, County	1	0c. City, Town or L	ocation						1	10d. Inside City Limit
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	ţo	MARYLAND MONTGOME	RY	POTOMA	C							1 ☐ Yes 2X No
r 288	Irec	10e. Street and Number				ip Code	-		11	Og. Citizen of	What Cou	ntry?
23a o	Funeral Director	11213 ANGUS PLACE				208						OF AMERIC
tams er m	une	11. Marital Status	12. Was Decedent Ev Armed Forces? 1 Yes 2 ANo	er in U.S. 13.	Was Deci	edent of H ecify Cuba	ispanic Orig in, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri ck, White,	
r, or l	oy Fi	1 Never Mamed 2 Married 3 Widowed 4 Divorced	1 ∐ Yes 2 LANO If Yes, Give Year or Dates:		1 🗆 Yes	2 <b>X</b> No	Specify:			Specia	y: WHI	TE
eal E	Be Completed by	15. Decedent's Edi	ucation	16a. Dec	dent's Us	ual Occup	ation			16b. Kind of E	lusiness/In	dustry
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matic	은	19a. Informant's Name/Relationship (T			ina Addres	ss (Street			al Route Number,	City or Town	, State, Zip	Code)
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other		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Na	ame of				20c. Location		own, State
nt: H ry or		1 A Burial 2 Cremation 3 □ 1 Donation 5 □ Other (Specify)		BEVERLEY	-			. 01	1/28/04	BEVE	RLLY	HILLS, FL
porta y inju		21. Signature of Funeral Service Licens							MEMORIA			INC.
E & 8		Jory 1	Thui		170	ROCKV	ILLE	PIKE	E, ROCKY	LLLE,		0852
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attending phy I for use as th	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1☐Live birth 2	☐Fetal death 3	□Ectopic □ Other (:	pregnancy	- 13			T.	ate of delivi onth	ery Day Year
the a	ysic	1 Yes 2 No	4 Pregnant at tir 9 Unknown	ne or death 5	□ Otner (	specity)				;		
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g 9									1 □ Y€	s 2 No	3 🗆 Prol	oably 4 🗆 Unknow
pe g	d by								24a. Was a		Were auto	ppsy findings available
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s certificate has been sign director, page 2 should be	Be Completed	examiner? XX 2 No	Hospital: 1 Napatient				er: 4 🗆 Nu		me 5 Reside	1 .		
s certilicate has been sign director, page 2 should be	To Be Completed	examiner?  XX 1	28a. Date of Injury (Month, Day)		of	28c. Injur Wor	er: 4 □ Nu y at k?		me 5 Reside	w injury occu	rred	
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Medi xamir		Bob B. Myers  4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location o	of Death	Feb.	26 4c. Coi	unty of Death	4 8:26 A
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State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** WILLIAM GEORGE MOORE MARCH 18,2004 12:29PM /Medical 4b. City. Town, or Location of Death 4a Fecility Name (If not institution, give street end number) TER LA PLATA

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

NOV • 24, 1918 4c. County of Death Examiner REHAB . CENTER CHARLES CO.NURSING & CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 6. Sex **Funeral** 1 □ M 2 □ F 85 Director 577-22-6051 MARYLAND Usual Residence of Decedent the Merylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show traumatic event, the Medical Examiner must be notified a 1 ☐ Yes 2 ☐ No Director MARYLAND CHARLES LA PLATA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number e filed within 72 hours efter death with al Hygiene. other than "natural", or items 23s or 10200 LA PLATA ROAD 20646 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status ☐ Yes 2√7 No Yes, Give X 1 Never Married 25 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: Specify: WHITE Completed by 3 □ Widowed 4 □ Divorced Year or Dates: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISTRIBUTOR 12 SINCLAIR OIL COMPANY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peges 1 end 2 should be f nent of Heelth end Mental F int: If Item 27 is marked of NATHAN C. MOORE LORENA BOWLING 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9940 POORHOUSE ROAD MARY BERRY MOORE-SPOUSE LA PLATA, MD. 20646 other 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Depertment of important: If it any injury or conce. ST. IGNATIUS CEMETERY 3-22-04 BEL ALTON, MARYLAND 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Physician Immediate Cause (Final disease or condition resulting in death) IV - dlc si MONA Examiner Due to (or as a consequence of) edical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The lew requires that the deeth certificate be executed es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 2 No 1 Tes ours efter deeth.

eral Director: After this certifice filled in by the funeral director. 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 3□ DOA 1 Yes 2 No Nursing Home 2 ER/Outpetient 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 🗠 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) YNN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 5 2004

**DHMH 16 Rev 6/95** 

Registrar

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		A	MEND ITEM #9 PER FH 1. Decedent's Name (First, Midd		3/24/0	)4 JH		- unca	e or	Dealli	2. Date of De		04	3. Time of Death
	Physicia /Medic		MARGARET F. I	ACCL(			_				Feb 20		Year	4:17 pm
3	Examin		4a Facility Neme (If not institution	_					'	4b. City, Town, or Lo				
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П	Funeral Director		5. Social Security Number 233 34 5450	6. Sex 1□	M 21X	90	Yrs. lest billing	Months		Hours Min.	Month, Da Nov 25	y, Year)		lace (State or Foreign try) TRGINIA
	P .	ļ	Usual Residence of Decedent			100	c. City, Town o	v Location					1	0d. Inside City Limits
	show	<u>_</u>	10a. State 10b. Count			100								1 ☑ Yes 2 ☐ No
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	leath ms 23	Funerai	1100 Mary Dr		12. Was Dec		in U,S.	13. Was Dece	dent of H	lispenic Origin? (Sp	ecify Yes or No		e - Americ	
Maryland 21215-0020	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or Itams 23a or 28a-f show reumetic evant, the Medical Examiner must be notified at	by	1 ☑ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2 No ive No		if Yes, spe 1 ☐ Yes		an, Mexican, Puèrto Specify:	Hidan, etc.)	Specify	k, White, : Whit	
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and	e da la	Be c								_			•	
2	shoufe nd Me mark matic	2	John Henry Mo			-	19b. N	failing Addres	s (Street	Jessie and Number or Rur	BELL K1	rpy er, City or Town,	State, Zip	Code)
	ロサトゥ		Cecil McCloud	i			PC	Box 3	20	Kitzmille	er, MD	21538		
re,	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic	Ì	20a. Method of Disposition				Ob. Place of D	isposition (Ne crematory or	me of other plac	ce)	Date	20c. Location -	City or To	wn, State
Ē	Page nent c int: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (.		emoval from	State	Kall	oaugh C	emet	ery Fe	b 23 0	Elk G	arde	n WV
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other pnce.		21. Signature of Funeral Service	License	Pe VA.	101	20	710	Chu	ss of Facility rch St. . Burdock	Kitzmil	ler,MD	2153	8
	151.00		23a. Part1. Enter the disease, of	r complic	cations that	caused the	death. Do no					rrest,	1	Approximate Interval Between
	Physician		shook, or heart failure. Lis									,	1	Onset and Death
	/Medical		Immediate Cause (Final disease or condition	а	M	40	cav	die	0	Inf	arc	tran		weeks
1/2	Examiner	<u>.</u>	resulting in death)			Due	to (or as a co	nsequence of)	:				1	
	ted nsit	Examiner		b.									- 1	
,	execunate and all train	Exar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			Due	to (or as a co	nsequence of)	:				1	
8760,	cate be executed physician and s the burial-transit	dicai	Cause (Disease or injury that initiated events	C.		Due	to (or as a cor	nsequence of)	:					
9	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial-transit	/Med	resulting in death) Last	L d									1	
Box	es that the death certification of the attending for the attending be detached for use as	Physician/Me	Part II. Other significent condit	one conf	tributing to d	leath but no	t resulting in t	ne underlying	cause niv	ren in Part I	23b. Did	tobecco use con	tribute to	the ceuse of deeth?
Ö.	t the c by the	hys	ratti. Other significent condit	Olis Com	tributing to a	outh but no	e recounting in a	io andonying	g.,		1 🗆	Yes 20 No	3 ☐ Prot	pably 4 Unknown
S, P	gned gredet	by P												
ord	v require been si should l	ted										en autopsy rmed?	ava	ere autopsy findings ailable prior to mpletion of cause
Vital Records,	aw 2 s	Completed										1/	of	death?
E	The cate h										101	res 20No	1 🗆	☐Yes 2☐ No
Vit.	ician certifi rector	Be	25. Was case referred to medic examiner?		ospital:		• C 5010		Oth	26. Place of Deat	10		· · /Consit	
ō	Physician: r this certific rral director,	5	1 ☐ Yes 2 ☐ No 27. Manner of Death		1 ⊔ 28a. Date	of Injury	2 ER/Outp		28c. Injur Wor	1		dence 6 ⊡Othe now injury occurr		//
on	ding th. : After s fune	tion	1 Natural 5 ☐ Pend	ng igation	(Mor	nth, Day Yea	a <i>r)</i> Inju	iry M		1k? Yes 2 □ No				
Division	Attending or death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could	not be	28e. Place	e of Injury - ling, etc. (S	At home, farm	, street, facto	ry, office		28f. Location (S	Street and Number	er or Rura	l Route Number,
Ö	tal or is afte al Dir	Certification:	17											
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier 1	ng Phys I Examin	er: On the b	e best of my pasis of exa nner stated.	knowledge, omination and/o	death occurred or investigation	dat the tir	ne, date and place, pinion, death occur	and due to the red at the time,	date and place, a	and due to	the cause(s)
	Within	W	29b. Signature and title of certifi	er 1 T	noc	0 6	7C)	29	c. Licens	e number		29d. Date signed	(Month, i	Uey, Year)
		ŀ	30. Name and address of person							-101			/	1
_			P. Daniel M				lf Acre	s Dr.	Oak	land,MD	21550			
	Sta		31. Date filed (Month, Day, Year	400	2004	Registrar's	4		W -					
211	Registr	al -	1 LD	~ 11	2004	A second	ie st	Ann						

State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar AMEND ITEM #20b P.	ER FH G829 3	/25/04 <i>Cs</i> H	rtificate of	Death	vicinal riy	Reg. No.	4 09399
Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Yea	3. Time of Death
/Med	ical	JAMES WII  4a. Facility Name (If not institution, give street		RAM, SR		Location of Death	MAR	1 2004	6:35 ™
Exami	ner	NATIONAL NAVAL ME		TER		ETHESDA		_	GOMERY
Funeral Director		5. Social Security Number 6. Sex 12 M		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 08-08-	9. B y, Year) -1931 No.	irthplace (State or Foreign Country) rth Carolina
land ow		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits
e Man	ctor	Maryland Anne Arunde	el	A	nnapolis				1 □ Yes 2X No
with the	Dire	10e. Street and Number 242 Autumn Chase Driv	70		10f. Zip Code 214	101		10g. Citizen of What	Country?
Jeath v	Funeral Director	11 Marital Status 12. W	as Decedent Ever in	U.S. 13.	Was Decedent of H		pecify Yes or No-	USA - 14. Race - Ar	nerican Indian,
urs after o	b	1 Never Married 2 Married	med Forces? ¶Yes 2□No Yes, Give ear or Dates: 194		If Yes, specify Cuba 1□ Yes 2 <b>XX</b> No	Specify:	o Rican, etc.)	Specify:	White
Ite, IVIAL YIALLA ZICLIOUDO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentai Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar mark to inclified at	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)	n npleted) ollege (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor d)	king	16b. Kind of Busines	ss/Industry
led will lygien her tha			years	Staf	f Searger		no (First Middle	US Air :	Force
d be fi	) Be	17. Father's Name (First, Middle, Last)  Eldridge Early 1	Pegram				leda Inez		
shoul and Me s mark	ပ္	19a. Informant's Name/Relationship (Type, P		19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town, State	, Zip Code)
and 2 eaith a m 27 is		Gisela L. Pegram/ Wit	Ee	242	Autumn Chosition (Name of	ase Driv	e, Annar	xolis, Mar	yland 21401
ages 1 nt of H re rifts		20a. Method of Disposition  1 🛣 Burial 2 🗀 Cremation 3 🗀 Remove	ini from State	cemetery, crei	matory or other place Natl. C		04	Arlington	
Dallillor permit. Pages 1 Department of H Important: If its any injury or ot once.		*4 □Donation 5 □ Other (Specify)  21. Signature of Juneral Service Licensee	211				orge P.	Kalas Fun	
Depariming the policy of the policy in policy		I flater to alle		2	973 Solon	ons Isla	nd Rd. E	dgewater,	MD 21037
Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition	use on each line.		ter the mode of dyir			rest,	Approximate Interval Between Onset and Death
/Medica		resulting in death)	Due to (or as a cons		OOROIMIR	MILIMI	DICHMOL		
1		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):					
cuted nd ransit	amin	cause. Enter Underlying Cause (Disease or injury that initiated events c							
oof ou, tificate be executed by physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a cons	equence of):					
do / ou, rificate be ex ng physician as the buria	edica	d							
death cer death cer e attendir	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   9 □ Unk	yes, outcome of preg □Live birth 2 □Fe □Pregnant at time o □Unknown	etal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of o Month	delivery Day Year
s that t	by Ph	Part II. Other significant conditions contribu	ting to death but not r	esulting in the u	inderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
w requires that the been signed by the should be detached			<del>-</del>				101	/es 2 □ No 3 □	Probably 4 Nunknown
The law ate has b page 2 st	Completed						24a. Was autop perfor 1 Kyes	rmed? prior to death	autopsy findings available o completion of cause of ? es 2XI No
OI VILAI P Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ial:		ot 3 DOA Oth	or	ath (Check only o		
this at dia	1: To	TE TOS ZEXINO	1 X Inpatient 2  2. Date of Injury (Month, Day Year)	☐ ER/Outpatier 28b. Time o	11 3D 00A	4 🗆 ivursing r	,	dence 6 Other (Sp now injury occurred	pecify)
ath.	atlor	2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No			
DIVISION of the control of the contr	Certification:		Be. Place of Injury - Al building, etc. (Spe	home, farm, sti cify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
To the Hoapital or Al within 24 hours after or To the Funerel Direct completely filled in by	edical (	29a. Certifier (Check only one)  1 Certifying Physicie 2 Medicel Examiner:	n: To the best of my k On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the til vestigation, in my o	ne, date and place pinion, death occu	, and due to the dirred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To the comp	×	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mo	,
		· Crul there	lam	lom 23a) Circ				MARCH CENT	
		30. Name and address of person who complete ERICH F. WEDAM LT	MC USNR	ein zsa) (Type,		ATLONAL N ETHESDA M		OICAL CENT: -5600	£K
		31 Date filed (Month, Day, Year)	32. Pagistrar's Sig	inature					

Registrar

MAR 0 5 2004

			1 - For State Registrer	State of Maryland	-	artment of F		d Mental Hy		2004	09400
	Physici		Decedent's Name (First, Middle, Last     RALPH A •	PYLE				2. Date of De Month	eath Da	y Year Zooy	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	-	4b. City, Town, o	r Location of D		40	. County of Death	
			UNION HOSPI			ELKTON	I William 04	Hen I a m i i m		ECIL	
1	Funeral Director		5. Social Security Number 6. Se 214-34-3757	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	Hours N	Min. 8. Date of Bi (Month, D OCt.	rth a <i>y, Year)</i> 26	Cou	place (State or Foreign ntry) Maryland
	D		Usual Residence of Decedent	10- 0:	<b>T</b>						
~	arylar show	_	10a. State 10b. County		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2X No
	Ne W	Funeral Director	MD Cecil  10e. Street and Number	Che	sape	ake Cit	У		10g Ci	tizen of What Cou	
	with a or i	흡		aratine Da							,
	death ms 23	era	1040 N. St. At	12. Was Decedent Ever in U.S.	. 13.	21915 Was Decedent of H	Ispanic Origin	? (Specify Yes or N		14. Race - Ameri	
9	within 72 hours after death with the Maryland Jiene. rithen "neturel", or tiems 23a or 28e-f show I're Madical Experience results and filed at	y Fur	1 Never Married 2 Married	Armed Forces? 1  ☐ Yes 2 X No If Yes, Give	1	if Yes, specify Cuba 1 ☐ Yes 21X No	Specify:	uerto nican, etc.)		Black, White, Specify:	White
Maryland 21215-0036	hours lurel',	ed by	3 X Widowed 4 □ Divorced  15. Decedent's Edi	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b K	(ind of Business/Ir	
75	in 72	Completed	(Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired	during most of d)	working	100.1	and of Businessan	idustry
212	d within giene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	F	armer			Fa	rming	
b	be filed ital Hygi d other event, II	Bec	17. Father's Name (First, Middle, Last)					Name (First, Middle		Sumame)	
yla	s 1 and 2 should be filled I Health and Mental Hyg Item 27 Is marked othe other treumatic event,	ို	Adin Pyle					ie Evere			
Nar	12 sh n and r is m		19a. Informant's Name/Relationship (7)			·		r Rural Route Numb			
e,	is 1 and 2 of Health a item 27 is other trei		Janet Titter  20a. Method of Disposition	(daughter)	ce of Disoc	Box 145 sition (Name of		sapeake Date		ocation - City or T	
nor	Pages nent of int: If it		1⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		natory or other place. Cemeter	1	23/04	Che	saneak	e City MD
Baltimore,	permit. Pages Department of Important: If i eny injury or once.		21. Signature v. F. in ral Server does		G <sup>2</sup>	Name and Addre	ss of Facility ineral		f St	ephen	L Schaech
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of							i, MD.	Approximate Interval Between
8760,	death certificate be executed  Examinate the authoring physician and ior use as the burial-transit	ical Examiner	Immediate Cause (Final disease or co-dition resulting in feath)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conseque  b. Due to (or as a conseque  c. Due to (or as a conseque  d.	BLA!		( INDM)			(15)	Onset and Death
.O. Box 68	death certifii e attending p id for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3[	□Ectopic pregnancy □ Other (specify)	y			23d. Date of deliv Month	ery Day Year
<u>α</u>	es that igned b	by Pt	Part II. Other significant conditions co	ntributing to death but not result	ing in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco	use contribute to t	the cause of death?
ord	w require been si should b	ted						_   10	Yes 2	-	
of Vital Records,	The lar ate has page 2	Completed			-			24a. Wa: auto perf 1 ☐ Yes		death?	opsy findings available ompletion of cause of
/ita	Physicien: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		oth		Death (Check only			_
of	Physi this c	2	1 Yes 2 No	Leginpatient 2 LE	R/Outpatier 28b. Time o	IL 3 DOX	4 LI NUISI	ng Home 5 🗆 Res 28d. Describe			fy)
uo	ding h. h. After funer	ton	1-☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	rk? Yes 2.∐No			,	
Division	Attending ir death. ector: After by the fune	Certification:	3 Suicide 6 Could not be	286. Place of injuly - At non	ne, farm, st	reet, factory, office		28f. Location City or To	(Street a	nd Number or Run	al Route Number,
Ö	i Sife	Cert	4  Homicide	building, etc. (Specify)				Only of the	wn, Stati		
	Fur 4 h	edical (		vsician: To the best of my knowliner: On the basis of examination and manner stated.							
	To the within 2 To the complet	ž	29b. Signature and title of certified			29c. Licens		10		ite signed (Month,	
			* Kahat			,	0584	19	Mar	19,20	Fox
u	6		30. Name and address of Person who of RODNEY DONAM, I		23a) (Type, STRET	Print) ELKTON	am, u				
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu							
	Regist	rar	MAR 2.5.2	804 Margines	B A	Carling !					

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:40 P M February **25**. 2004 Ruberto /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 21372 Sharp Street Rock Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐**X**M 2 ☐ F March 12, 58 1945 New Jersey Director 222-28-1559 Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD. Rock Hall Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21661 USA 21372 Sharp Street death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2X Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tankerman/Barge Captain Oil Company 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is merked other any injury or other traumatic avent, It 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Josephine Spirito 2 Frank Ruberto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21372 Sharp Street, P.O. Box 433, Rock Hall, MD. 21691 Winifred Ruberto (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) March 2, 2004 Bear, Delaware Delaware VA. Cemetery 21. Signature of Funeral Service Licenses Fellows, Helferbein & Newman Funeral Hune, P.A. 130 Speer Road, Chestertown, Maryland 21620 Kick Of Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one rose on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AMER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Completed by Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death use. 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? detached for 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BANN METASTHATIC LES mm 23e. Did tobacco use contribute to e cause of death? signed t of Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) filled in by the funeral director Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 Y96 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. May er of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation Injury Hospital or Attending 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier DBEOLA MP d cause of death (Item 23a) (Type, Print) 120 SPEan Ad CHESTEAN nich 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 02

DER	State of Maryland / Department of Health and Mental	Hygie
1 - State Registrar AMEND_ITEM #4c	PER ME G829 3/25/04 Grantificate of Death	Reg

Physician	
/Medical	
Examiner	

Valerie Jean Sheeder

1. Decedent's Neme (First, Middle, Last)

4b. City, Town, or Location of Death **CUMBERLAND** 

4c. County of Deeth WASHINGTON ALLEGANY

2004

**Funeral** Director

or 28e-f show

0.

"natural".

Hygiene.

item 27

permit. Pages 1 Department of H Importent: If ite eny injury or ot once.

**Physician** 

/Medical

Examiner

the attending physician and hed for use as the burial-tran

detached for

peed

certificate has

within 24 hours To the Funeral

or Attending Physician: ours after death.

neraf Director; After this certific filled in by the funeral director.

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

other traumatic event, the Mudical Examinar must be notified at

fijed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Usual Residence of Decedent 10a State Director Funeral þ Completed

Be

Examiner

Physician/Medical

þ

Be Completed

Certification: To

Medical

4a. Fecility Name (If not institution, give street and number) MEMORIAL HOSPITAL 5. Social Security Number 6. Sex 1 □ M 2 🛱 F 173-60-3384

7. Age (In yrs. last birthday) Yrs 10c. City, Town or Location

If Under 1 Year | If Under 24 Hrs. Days Hours Min

8. Date of Birth (Month, Day, Year) December 15,1968

2. Date of Death MARCH

> Birthplece (State or Foreign Country) PA

> > 10d. Inside City Limits

1 ☐ Yes 2 1 No

0252 AM

PA Fulton 10e. Street and Number

Warfordsburg 10f Zip Code

10g. Citizen of What Country?

USA

494 Schultz Road 11. Marital Status

1 ☐ Never Married 2 ☐ Married

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ZY No
If Yes, Give
Year or Dates:

17267 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐XNo Specify:

Black, White, etc. Specify: White

14. Race - American Indian,

3 Widowed 4 Divorced

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16h Kind of Business/Industry Home Construction

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumame)

Virl H. Sheeder 19a. Informant's Name/Relationship (Type, Print)

Secretary

Violet J. Stotler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Virl H. Sheeder/Father 20a. Method of Disposition

356 Schultz Road Warfordsburg, PA 17267 20b. Place of Disposition (Name of cemetery, crematory or other place)

1 XBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify)

Zion Lutheran Cemetery 03/15/04 22. Name and Address of Facility

inquie

Warfordsburg, PA 141 West Main Street

21. Signeture of Funeral Service Licensee

Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one,

24b. Were autopsy findings available prior to completion of cause of death?

123 es 2□ No

25. Was case referred to medical examiner? 1 XYes 2 No 27. Manner of Death

5 Pending

investigation

6 Could not be determined

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 3-11-04

5

28b. Time of Injury 12:54AM 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 Yes 2 XNo

vehicle wht Deceased anving road 281. Location (Street and Number or Rural Route Number, City or Town. State) wood Mont Rule Walkington Co. M.D.

29a. Certifier (Check only one)

1 Natural

2 Accident

4 - Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and tiple

29c. License number O.C.M.E

road

29d. Date signed (Month, Dey, Year) MARCH 11, 2004 11,

30. Name and address of person who gompleted cause of death (Item 23a) (Type, Print) 12 HOGIAT

31. Date filed (Month, Dey, Year)

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

gardes!

State Registrar

		•	For State Registrar	State	of Ma	arylan	d / Depa <i>Cer</i>	artment				lental H	lygie Reg.	ne <sub>No.</sub> 21	004	0.9	1403
			1. Decedent's Name (First, Middle									2. Date of Month		Day	Year	3. Time of	
	Physicia /Medic	al	Lewis Everett S				1					March	2,	2004	-4 D11	10:0	07a. <sup>™</sup>
	Examin	_	4a. Fecility Name (If not institution					4b. City,						4c. County	or Deeth		
			Chester River F	6. Sex			ast birthday)	If Under	-	town		8. Date of	Birth	Kent	9. Birthp	lece (State	or Foreign
4	Funeral Director		217–36–0187	1 <del>M</del> M 2□F		91	Yrs.	Months	Days	Hours	Min.	8. Date of (Month, 3/31/	191	ear) 2	Mary	try)	
			Usual Residence of Decedent												14	0d. Inside C	ib. Limite
	deeth with the Maryland rme 23e or 28a-f ehow	_	10a. State 10b. County			·	, Town or Lo								1		3 □ No
	Be-f	Director	Maryland Queen	Anne's			Millin	10f. Zip	Code				100	Citizen of \	What Coun		X
	e or ?	5	439 Chester Riv	or Heigh	te F	heo?		101. 2.0		2165	1			USA			
	deeth	Funeral	11. Marital Status	12. Was De	ecedent l		S. 13. \	Vas Deced	ent of His			ecify Yes or Rican, etc.)	No-	14. Rac	e - Americ		
	or Ite	F	1 ☐ Never Married 2 ☐ Marr	ied 1 Yes	Forces? s 2 7 h	No		1 ☐ Yes 2		Specify		riloan, otc.,		1	Whit		
003	n 72 hours after deeth with the Marylan "naturel", or teeme 23e or 28a-1 ehow edical Exacili or mast to notitied at	d by	3 Widowed 4 □ Divorced	Year or	Dates:		16a. Deced						161	b. Kind of Bi			
5	"nat	lete	15. Deceden (Specify only highes	t grade complete			(Give	kind of wor	k done d e retired,	lu <i>ring</i> mos )	st of worki	ing	100	J. KING OF BI	23111033/1110	Justiy	
212	filed within 72 hours after Hygiene. Ither than "naturel", or Ite ent, Ire Medical Exarilina	Completed	Elementary/Secondary (0-12)	College	(1-4or 5	)+)	Bus C	ontra	ctor				Pu	blic S	Schoo	ls	
Maryland 21215-0036	- 05	BeC	17. Father's Name (First, Middle,	Last)						18. Moth	er's Name	First, Mide	dle, Mai	den Suman	10)		
Va Va	2 should be and Mental is marked o	To E	James Bedford S									e Ever				- 11.	
Jan	2 sho		19a. Informant's Name/Relations									al Route Nu					21651
	is 1 and 2 should of Health and Mer flem 27 is merke other treumatic		Bonnie Savage/D	augnter		20b. P	lace of Dispo				-	nts Ro		. Location -			1001
o o	m O - L		ty Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	3 Removal fro	m State		<sub>emetery, cren</sub> lersvi				3/6/	/2004	S	ndler	:vill	a Mar	cvland
altimore,	글로판출 .	1	21. Signature of Funeral Service	Licens#e			22	. Name an	d Addres	s of Facil	ity						
B	Depa Impo eny id		Daw B.	1000.	1_		Fe	llows	He	lfen	bein Stree	& New	nam	Funer	cal Ho	ome, I	?.A.
			23a. Part1. Enter the disease, or shock, or Meart lailure. List	complications that	it caused	the death	n. Do not ent	er the mod	e of dying	g, such as	s cardiac o	or respirator	y arrest	,		Approxima Intervat Be	tween
) }	Physician		disease or condition		Kne	um	once									Onset and	C-4
	/Medical Examiner		resulting in death)	Due		a consequ											
	LAMITIME	_	Sequentially list conditions, if any, leading to immediate	b. — Due	to (or as	a consequ	uence of):		<del></del>								
	ned Insit	Examiner	Cause (Disease or injury	<b>(</b>													
Ć	te be executed ysician and e burial-transit	Еха	that initiated events resulting in death) Last	Due	to (or as	a consequ	uence of):										
3760,	A × 0	ical		d											-		
68	entifica ling ph e as th	Med	IF FEMALE:	22a Muse		of progna								004 0-	A		
P.O. Box	eath certific attending pl	ian/	23b. Was decedent pregnant in the past 12 months?		e birth	2 ∏ Feta t time of d	Ideath 3 ☐	Ectopic pr						1	te of delive onth		Year
o	that the de led by the a detached t	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Un				2 0 11101 (0)					-				
	The law requires that the death certifica ate has been signed by the attending ph age 2 should be detached for use as th	by Physician/Med	Part II. Other significant condition					nderlying c	ause give	en in Part	l.	23e. D	id tobac	co use cont	tnbute to th	ne cause of	death?
rds	v requires been sign should be	ed b	Vertabral	CON	2 PV	res:	sion	tr	ac	TCV	(	1	Yes	2 1 1√10	3 Prob	ably 4 🗌	Unknown
900	ne law requ has been ge 2 shoul	Completed										24a. W	itopsy		prior to cor	psy lindings	available cause of
œ —	Physician: The this certificate ha	Com										1 ☐ Ye	arforme s 2 ☑		death? 1 🗌 Yes	2 No	
/ita	icien: Th certificate rector, pag	Be (	25. Was case referred to medica examiner?	Hospital:	1				Othe	ar		h Check on					
of \	Physicien: r this certifica ral director, p	<u>و</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	11	te of Inju		ER/Outpatier 28b. Time of		JA	4 📙 N		me 5 R 28d. Descri				y)	
no	After After funer	tlon	1 ☑ Natural 5 ☐ Pendir	ng (M	lonth, Da	y Year)	Injury	М	8c. Injury Work	k? Yes 2 [				, , , , , ,			
Division of Vital Records,	Attending or death.	fica	3 Suicide 6 Could	not be 28e Pla	ace of Inj	jury - At ho	ome, larm, str	reet, factor	, office		-	28f. Locatio	n (Stree Town, S		per or Rura	i Route Nur	nber,
á	s after	Certification:	4 Homicide	bu	liding, et	ic. (Specii	y)				1	0.1,7 0.1	, OW, , c				
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		(Check only 2 Medical	ng Physician: To Examiner: On the	e basis o	f examina	wledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date a pinion, de	nd place, ath occurr	and due to I red at the tin	he caus ne, date	se(s) and ma and place,	anner as si and due to	tated. the cause(	s)
	thin 2, the P mplet	Medical	29b. Signature and July of certifie		anner st	ated.		29	. License	number			29d	. Date signe	d (Month,	Day, Year)	
	Z 3 Z 8		N In On	rell			10		DO	000	388	24	1	nan	- h	4. =	1004
			30 Name and address of person	who completed c	ause of o	death (Iten	п 23а) (Туре,	Print)	10		0		1.	14	20	1/0	5
			Paul Don	aller,	M	$\mathcal{U}_{\perp}$	119	C 1	Mai	In	St	69,	8N	4 W	1) 6	116=	5 2
	Sta Regist		31. Date liled (Month, Day, Year,		. Hegisti	rar's Signa	nure	melle	,								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Nettie March 3, 2004 12:40A Pauline Tavlor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sep 26, 19 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 1 □ F 218-24-9865 74 1929 Maryland Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland , and Mental Hygiene. Is marked other than "natural", or Items 23a or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Frederick Rocky Ridge Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8990 New Cut Road 21778 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 MgNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White \$ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Child Care Provider Child Care 8 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be nit. Pages 1 and 2 should be fartment of Health and Mental Fortent: If Item 27 is marked of Lambert Paul W. Cora Eva Blubaugh ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna Jean Knott/Daughter 8970 New Cut Road, Rocky Ridge, Maryland 21778 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition η☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) = 5 St Paul's Cemeterv Mar 6, 2004 Thurmoit, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home

106 Fast Church Street, Frederick, MD

23a. Spart. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Appropriate Course (Fine) 21. Signature of Funeral Service Licensee permit.
Departr
Importa 21701 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Infarction Hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 Å No 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Severe Emphysema 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? page this certificate 2 □ No 1 ☐ Yes 2X No 1 🗌 Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ₹ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death.

nerel Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funerel 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D22101 March 3, 2004 lun) N 30. Name and address of person to completed cause of death (Item 23a) (Type, Print) Lloyd E. Halvorson, M.D., 1475 Taney Avenue, Frederick, Maryland 21702 31. Date filed (Month E Registrar's Signature R 2 5 2004 State

DHMH 17 Rev 1/2001

Registrar

	For State Registrar	State of Marylan	d / Departn <i>Certifi</i> e	nent of Hea cate of De	Ith and Math	ental Hygie	ene 20	04 09	1405
Physician	1. Decedent's Name (First, Middle, Last)		-			2. Date of Death Month March 1	5 200		of Death
/Medical Examiner	4a. Facility Neme (If not institution, give s	street and number)		City, Town, or Loc	ation of Death	1102011 2	4c. County o	of Death	
704	Upper Chesapeake  5. Social Security Number 6. Sex			Bel Air		8. Date of Birth		ford  9. Birthplace (State	or Foreign
Funeral Director	215-54-2126	M 2□F 55			ours Min.	April 24	(°1/948	Marylar	ıd
pug *	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	, Town or Location	1				10d. Inside	City Limits
in the Marylar or 28a-1 show a notified at			hite Ha					1 🗆 Ye	s 2 No
with the Mar tor 28s-1 at be notified	10e. Street and Number		10	f. Zip Code			g. Citizen of W		
s 23a o	2726 McComas R		S 12 Was I	21161	ora Origina /Son		U.S.A.	- American Indian,	
re, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-1 ahow other traumatic event, tra Medical Examinar must be notitled at To Be Completed by Funeral Director	11. Marital Status  1 XNever Married 2 Marned  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Decedent of Hispai specify Cuban, Mes 2 No Si		Rican, etc.)		White, etc.	
21215-0036 ed within 72 hours all spiene. Part then "natural", or it, tra Medical Evant	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation a co <i>mpleted)</i> College (1-4or 5+)	(Give kind life. DO N	Usual Occupation of work done durin OT use retired) Employe	g most of worki	ng 16	5b. Kind of Bus	siness/Industry	
15, 11 Hygie other the want, the	17. Father's Name (First, Middle, Last)		Never			(First, Middle, Ma	aiden Sumame	)	
laryland and Mental H is marked out	Albert L. Evan	s		F	Edith E	auline	Troye	er	
altimore, Maryland rmit. Pages 1 and 2 should be file partment of Health and Mental by portant: If then 27 is marked oth yinjury or other traumatic avantice.	19a. Informant's Name/Relationship (Ty) Edith Pauline Mit					<i>R</i> oute Number, 0 White H		State, Zip Code) MD 21161	1
timore, Martimore, Martimore, Martimore of Health a rearrier if them 27 is nightly or other treatment or oth	20a. Method of Disposition	20b P	_l lace of Disposition	(Name of	March			City or Town, State	
4) 000	1 XBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	temoval from State We	ernetery, cremator Sley Cha Cemeter	pel	2004	1 19,	Monkto	on, MD	
Baltimo	21 Signature of Funeral Service License	4. 10.1	J. J 24	ne and Address of • Harter Second	rstein St., 1	Mortua New Fre	ry, Ir edom,	nc. PA 1734	9
1,750	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	cations that caused the death ne cause on each line.	n. Do not enter the	mode of dying, su	ich as cardiac o	r respiratory arres	t,	Approxim- Interval B Ons, t a co	etween,
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	pire!	in	Ar	es I		7	lura
Examiner 5	Conventing the line conditions	, , , , , , ,	emon	Lasic	5	hoch		12	her.
23.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse-	Jence off:	jo	Pan	doan			1
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		. He	modi	1481) (	erat	dut	ecto	- Una	nen
Box 6 auth certific attending p for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3 Ecto	pic pregnancy or (specify)		W.A.WII	23d. Date Mont	of delivery th Day	Year
	Part II. Other significant conditions con	ntributing to death but not res	ulting in the underly	ing cause given in	Part I.			oute to the cause of	
Cord						V 200	1111		Minknown
_							d? de No 1	ere autopsy finding- ior to completion of eath? Yes 2 No	cause of
Robbotonians	25. Was case referred to medical examiner?	lospital: patient 2	ER/Outpatient 3[			(Check only one) ne 5 ☐ Residen		(Specify)	
Very Robon of Vita vision of Vita vi		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		8d. Describe how			
or At affer a Direct in by	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, f	actory, office	2	8f. Location (Stre City or Town,		r or Rural Route Nu	mber,
ld se line in le line		sician: To the best of my kno ner: On the basis of examina and manner stated.							(s)
To the Ho within 24 I To the Fu complete!	29b. Signature and title of certifier			29c. License nui	mber	290	I. Date signed	(Month, Day, Year)	
	) 104x			130	653		3	7-0>	
5	30. Name and address of person who co	neile - 50	20 hz	er the	rajeabe	Priv	e, Be	Anz	104
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ure .	fact of					

State of Maryland / Department of Health and Mental Hygiene 2004 09406 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2004 LOIS VANSANT FEBRUARY 29 1055 M Williams /Medical 4a. Facility Neme (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Director 214-28-8272 1932 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28e-f show 1 ☐Yes 2 ☐ No Directo Md. Rock Hall Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 6290 Rock Hall <u> 21661</u> Funeral Road
12. Was Decedent Ever in U.S.
Armed Forces? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) diner. 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2√元 No The Medical Exp. Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11th 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health and Mental H tent: If item 27 is marked otl Be 18. Mother's Name (First, Middle, Maiden Surname) ဥ Benjamin Clay Williams Pearl Meekins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6290 Rock Hall Road, Rock Hall, Md. 21661 Francis Vansant other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. Chesapeake Crematory 3/1/2004 Stevensville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fellows, Helfenbein & Newnam, Funeral
130 Speer Road Chestertown, Maryland 233 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) "Ander Physician UNIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physician and is the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) ned by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, sign. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital 2 X No or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No completely filled in by the funeral 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury Certification: 28d. Describe how injury occurred After 1 Natural Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 17840784 320may Ucm) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUNDS 122 Speer Road Chestertown, Maryland 21620 31. Date filed (Month, Day, Year) 32. Restrar's Signature State MAR O 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 4 09407 Certificate of Death AMEND ITEM #28f ME G829 3/24/04 Jh 2 Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY T2 2004 **Physician** 6:50 AM MARJORIE FOX WILLIAMSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Prince George's Cheverly Prince George's Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 17 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Yrs 75 Director 228-22-8292 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiments 200. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State M☐ Yes 2☐ No Fort Washington Directo Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20748 USA 7810 Prince George's Drive Funerai 14 Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 XX o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify: Specify: White 5 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Geneva Dunn Fox Rosco Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7810 Prince Geroge's Dr. Ft. Washington, MD 20748 Harvey D. Williamson (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial gardens 2-17-04 Waldorf, MD 21. Signatur of Furreral Service Licensee 22. Name and Address of Facility Eberwein Funeral Services M00173 4433 White Pls.Lane White Pls., MD 20695 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician (ene bro viscular Acident Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of): To Verte bral Fore twees Physician/Medical Examiner attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of)  $\mathcal{JSF}$ Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2\(\tilde{\Omega}\)No 3 ☐ Probably 4 ☐ Unknown ģ STrokes Š 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has funeral director, page 2 TL Yes 20 No 1 □ Yas 2 □ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) YYes 2□ No ۵ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 | Yes 2 No 0145 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State 810 PRINCE GEORGE'S DR. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide done FORT WASHINGTON MARYLAND 20748 To the Hospital of within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charly many lost 129 Hospital Drive 304 0

32. Registrar's Signature

Milus

2004

State Registrar 31. Date filed (Month)

State of Maryland / Department of Health and Mental Hygiene 004 09408 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MARCH Day Year **Physician** MARY AMODEI 22:10 PM E 24 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE NIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Fear) 4 Hours Min. January 10, 1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X Months Days 207-26-3513 69 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is merked other than "natural", or Items 23s or 28s-f show ury or other traumatic event, the Medical Exterimet is ust be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Delaware Sussex Directo Milsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? R R 13 Box 844 19966 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Complet (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Manager Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Mann Maxine Hood ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alleva Funeral Home Inc 1724 East Lancaster Avenue Paoli Pennsylvania 19301 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any injury or ot once. XX Burial 2 Cremation 3 Removal from State St Monica Cemetery 4 Donation 5 ☐ Other (Specify) 04-01-04 Berwyn, Pennsylvania ature of Funeral Servi 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EPSIS **Physician** 9 WEEKS /Medical Due to (or as a consequence of) **Examiner** (POLYMICEOBIAL) PNEUMONIA 5 squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WEEKS Due to (or as a consequence of): The law requires that the death certificate be executed COPD 20 WEARS and Due to (or as a consequence of) P.O. Box 68760, attending physician by Physician/Medical as IF FEMALE: US8 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ENDOCARDITIS HTN 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed CVA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy ESRD 1 Yes 1 Yes 2 No 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ŧ ٩ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ti⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 130 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kathi Davisono P16688 MARCH 24, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATHLEEN M. DAVIS, MD UNIVERSITY OF MARYLAND MEDICAL SYSTEM
22. S. GREEN ST BALTIMORE, MD 21201 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 6 2004

	1 - For State Registrar		aryland /	Department of Certificate of		R	og. No. 200	
an cal	1. Decedent's Name (First, Middle, Lawra	Baker				2. Date of Dea Month Morch	23 200 4	4 8:36 F
ier	4a. Facility Name (If not institution,		4	- 4	or Location of Deat	th /s ha	4c. County of De	ath
	5. Social Security Number	6. Sex 1 M 2007	dical Can be (In yrs., last b.				9. B	irthplace (State or For Country) SA
tor	Usual Residence of Decedent  10a. State 10b. County  Md			vn or Location				10d. Inside City Lir 1 Yes 2
Funeral Director	10e. Street and Number	Ch		10f. Zip Code	)		Og. Citizen of What (	
erai	601 N. Charles	12. Was Decedent	Ever in U.S.	21230			Jnited Sta	nerican Indian,
by Fun	1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed Forces?		13. Was Decedent of If Yes, specify Cu		to Rican, etc.)	Consider	nite, etc. hite
Completed	15. Decedent (Specify only highes	's Education t grade completed)	166	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire)	upation e during most of wo	orking	16b. Kind of Busines	s/Industry
mp	Elementary/Secondary (0-12) Unknown	College (1-4or	5+)	Jnknown	·9 <i>d)</i>		Unknown	
ပိ	17. Father's Name (First, Middle, I	Last)		STIRTIOWIT	18. Mother's Na	me (First, Middle,		
o Be	Unknown				Unknow	n		
-	19a. Informant's Name/Relationsh Barbara L. Gra			b. Mailing Address <i>(Stree</i> Department (				
-	20a. Method of Disposition		20b. Place	of Disposition (Name of ary, crematory or other pl			20c. Location - City of	
	1 Burial 2 VCremation  4 Donation 5 Other (Sp	pecify)		peake Cremat	tory 200	4	Beltsvill	
	21. Signature of Funeral Service I	) M	V8800	Crenation	and Fun	eral Alte	rnatives timore, M	a 21206
	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that cause only one cause on each l	d the death. Do	not enter the mode of dy	ring, such as cardia	ac or respiratory arr	est,	Approximate Interval Between Onset and Dea
	resulting in death)	11.	a consequence					
ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Lue to (or as	a consequence	01):				1 hour
Examiner	that initiated events resulting in death) Last	0.	ato f	adus:				1 1car
70		d. Chron	- 1		Lung d	iscase		10 y ca
Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Se No 9 ☐ Unknown		of pregnancy 2 Fetal deat it time of death	h 3 ⊟Ectopic pregnan 5 □ Other (specify)			23d. Date of d Month	lelivery Day Yea
by Ph		ens contributing to death t	out not resulting	in the underlying cause g	given in Part I.	23e. Did to	bacco use contribute	to the cause of deat
ed b	Di abetes	hypertens:	on to	range aut	eny distant	1 U Y	es 2⊡No 3 🕰	Probably 4 □Unk
Completed	Lypothypoids	tenal	disins	*		24a. Was a autops perfor	sy prior to	
BeC	25. Was case referred to medical	Livery str			26. Place of De	eath (Check only or		
10 0	examiner? 1 Tes 2 No	Hospital: 1  Inpati	ent ZERVO	dipatient 3 DOA		Home 5□Resid	ence 6 □Other (Sp	pecify)
Certification:	27. Manner of Death  SNatural 5 Pendin 2 Accident investig	pation		Time of 28c. In Injury M 1 [	ury at ork? □ Yes 2 □ No	28d. Describe h	ow injury occurred	
ertific	3 Suicide 6 Could r 4 Homicide determ	ined 200. Place of In	jury - At home, tc. (Specify)	farm, street, factory, office	е	28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number
1.75	29a. Certifier (Check only one)  Certifyin 2 Medical	g Physician: To the best Examiner: On the basis of and manner s	of examination a					
		1.4. 1 . 1	Dhacies	29c. Lice	nse number	2	29d. Date signed (Mo	nth, Day, Year)
Medical Co	29b. Signature and title of certifier	yest endens						
edicai		a A. Cort	unD	DO	05624	0	March 2	3,2004
edicai		A. Cons	death (Item 23a	DO (Type, Print)			March 2	3, 2004

			1 - For State Registrar	State	of Marylan	d / Depa	artmen rtificate	t of H	ealth a	and M	lental Hy		004	09410
	Physici /Medic		Decedent's Name (First, Mid     Mary	dle, Last) Elizab	eth		Bavis				2. Date of De Month March 2	Day	Year 004	3. Time of Death 08:43 A M
	Examin		4a. Fecility Name (If not instituti 1227 Crawford	Drive			Gle	en Bi	Location o	of Death		4c. Ce	ounty of Death ine Aru	ndel
	Funeral Director		5. Social Security Number 213-30-5547	6. Sex 1 □ M 2 <b>/</b> □ <b>X</b> F	7. Age (In yrs. 70	(ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Sep 5,	1933	9. Birth Cou	place (State or Foreign ntry) MD
	ith the Maryland or 28a-f show as notified at	Director	10e. Street and Number	Arundel	10c. Cit	g, Town or Lo	Burnie 101. Zip	Code				•	n of What Cou	10d. Inside City Limits 1 ☐ Yes 2XXNo ntry?
920	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event. The Medical Examiner must be nutified at once.	by Funeral Director	1227 Crawfox  11. Marital Status  1 Never Married 2 Marital Status  3 W Widowed 4 Divorce	12. Was Dec Armed F 1 ☐ Yes If Yes. G	2 No ve				spanic Ori n, Mexican Specify:	gin? (Spi n, Puerto	ecify Yes or No Rican, etc.)	)- 14	J.S.A.  Race - Amen Black, White, pecify: Wh	etc.
Maryland 21215-0036	iled within 72 ho Hygiene. Ther then "natur nt, the Medical	Completed by			1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us artenc	k doné d e retired,	luring mos		ing a (First, Middle	Food	& Beve	
yland	should be f nd Mental H marked of umatic ever	To Be	James Fletch	er George					Ida	Mae	Simmor	ıs		
	and 2 sh ealth and n 27 is m		Mr. Timothy Ba			1227	Crawt	ford	Driv	e G	a <i>l R</i> ou <i>te Numb</i> ilen Bur	nie,	MD 21	061
Baltimore,	Peges 1 ment of He lant: If iten jury or oth		20a. Method of Disposition  1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other	(Specify)		Place of Dispo cemetery, crei en Have	en Men	noria	al Pa	rk	25 2004	Gle	en Burn	ie, MD
Balt	permit. Departri Imports eny inju		21. Signature of Funeral Service	alles M	01364	1	Secor	id Av	enue	, S.	W. Gler	ı Burn		me, P.A. 21061
	Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	a	Met	es lati	er the mode	of dying	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	(or as a conseq				,					
68760,	icate be executed physicien and s the burial-transit	edicai Exar	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):								
.O. Box	The law requires that the death certificat its bas been signed by the attending phypage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mosths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	tcome of pregna birth 2 ☐ Feta hant at time of d lown	ldeath 3	Ectopic pre					230	d. Date of deliv Month	ery Day Year
ords, P.	w requires that been signed to should be det	by	Part II. Other significant condi	tions contributing to d	leath but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	/		he cause of death?
al Records,		Completed											24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available impletion of cause of
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medic examiner?  1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DO	A Othe	AFT.		me S Resi		Other (Special	fv)
ion of	ding After fune	ation: T	27. Mann Death 1 Natural 5 Pend 2 Accident inves	28a. Date (Mor tigation		28b. Time of Injury		3c. injury Work	at		28d. Describe			,,
Division	To the Hyspitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Couldetel	mined   288. Plac	e of Injury - At ho ing, etc. (Specif		eet, factory	office			28f. Location (: City or Tou		Vumber or Run	al Route Number,
1	he Haspitel or in 24 hours afte he Funeral Dir pletely filled in I	edical	(Check only 2 Medica		e best of my kno pasis of examina iner stated.	wledge, death	n occurred a vestigation,	at the tim in my op	e, date and inion, deal	d place, th occurr	and due to the ed at the time,	cause(s) an date and pl	nd manner as s ace, and due t	stated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certif	sell a	DE	1		License	) } /	JŚ	7	29d. Date s	signed (Month,	Day, Year) 12,1004
44	() Sta	te.	me and ad s of person	Deluc	J.D	> 30	Frint)	1050	n, to	10	) ne, (	Flens	B 21-my/	V. 21061
D.H.	Registr	ar	31. Date filed (Month, Day, Year MAR 2 6 2	2004	Registrar's Signa	Asa						_		

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HENRY BROADNAX /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N Sandtown Baltimore Winchester Nursing Home 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1215 Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M 2 □ F 239-48-NC Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b, County 10c. City. Town or Location or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 827 N. Arlina USA TOV Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or iten any injury or other traumatic evant, the Medical Examiner once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 XNo 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Buildir onstruction A 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mar Broadnax ware 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Arlington Avenue Baltimore MD 21217 Marie Hawkins 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 → Burial 2 Cremation 3 Removal from State MT. ZION BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICES Vans 5151 BALTIMORE NATIONAL PIKE BALTIMORE MD 21229 23a. Part1. Energy disease, or complications that caused the death. Do not energithe mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due ti Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a conseque ce of Examiner The law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 ☐ No Year Month Dav 4□Pregnant at time of death 5 Other (specify) tor: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Dunknown Be Completed 24b: Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred edical examiner? 26. Place Death (Check only one) Hospital: 2 DNO Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Latural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after death Funaral Diractor: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 \ Criting Physician: To the best of my knowledge, death occurred at the time, date and prace, and due to the cause(s) and manner as due to the cause(s) and manner stated.

2 \ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbei eath (Item 23a) (Type, Print) 30. Name and address of person wh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 6 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item #17 per fh G829 3/Belitificates of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) , 2004 Year MARCH 22, Da **Physician** 1:30 P PEARL BEUBIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL Months Days Hours Min. 8. Date of Birth (Month, Day Year) SEPT. 30, 1912 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 Ū F ROMANIA 91 Yrs. 264-54-4231 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director SILVER SPRING MONTGOMERY MD 10f. Zip Code 10g. Cilizen of Whal Country? 10e. Street and Number with 20904 U.S.A. 515 APPLEGROVE ROAD Items 23a Completed by Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "nstural", or Ite 1 Never Married 2 Married ☐Yes 2XNo Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates: Specify: 3 X Widowed 4 □ Divorced 16a. Decedeni's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME **HOUSEWIFE** 17. Father's Name (First, Middle, Last) Hyman Shapiro 18. Mother's Name (First, Middle, Maiden Sumame) Be CHADIDO YETTA GLICK - HERMAN 2 if Health and Milem 27 is mail other traumal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELENE RICH / DAUGHTER 5517 AMESFIELD COURT - ROCKVILLE, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 = 5 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) MORIAH CEMETERY 3/23/2004 FAIRVIEW, NJ 21. Signature of Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final **Physician** da resulting in death) /Medical **Examiner** rol Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of). Box 68760, Physician/Medical as the attending | IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at lime of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 Probably 4 DOnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗀 No certificate 1 Yes 2 23 No 1 TYAS Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After ! Certification: 1 Natural 5 Pending investigation 1 Yes 2 No М death. 2 Accident after death 6 Could not be 3 🗌 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, elc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the within 29d. Date signed (Month, Day, Year) 29c. License number of certifier MARCH 22, 2004 D50987 address of person who completed cause of death (Item 23a) (Type, Print) Box MO 83819 YAITHERS BURY AHMED PD 32. Registrar's Signature State Registrar

		For State Registrar	State of Maryla		artment of H <i>rtificate of L</i>		Mental Hygier Reg. 1	2001	00116
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a or 28a	Director	10e. Street and Number		DAV	10f. Zip Code	\ 3	10g. (	Citizen of What Coun	itry?
28	by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed ADDivorced	12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 Yes 2 No	spanic Origin? (Si n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
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int: If item 2 iry or other		20a. Method of Disposition  1 Surial 2 Cremation 3 4 Donation 5 Other (Specify	20b. Removal from State	Place of Dispo cemetery, cren	- Andrewson and American	9)	Date 20c.	Location - City or To-	wn, State
Important: If any Injury or once.		21. Signature of Foreign Service License	Lwynn		Name and Addres	s of Facility	LAN Func		
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to the Fundral Director: Atler this certificate has been signed by the atlending phicompletely filled in by the funeral director, page 2 should be detached for use as the	Σ∣	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	ry Day Year
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5		30. Name and address of person who c	Jow XIVO	TON	Print)	NE R	on moisi	· mo	-11-1
Stat	-	31. Date filed (Month, Day 4.	6 2004 Registrace Sign	nature	A SALL				

		4	State of Maryland / Department of Health and Me Certificate of Death	ental Hygiene 20	04 09414
	Physicia		Decedent's Name (First, Middle, Last)		3. Time of Death
	/Medic	al -	Karen Louise Cunningham  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of	
	Examin	e:	FRANKLIN SOUARE HOSVITAL ROSEDALE	13A/	TIMORE
	Funeral		5. Social Security Number 1 Months Days Hours Min. 1 M 2 XX 62 Yrs.	8. Date of Birth (Month, Day, Year) Sept. 12, 1941	Birthplace (State or Foreign Country) Vest Virginia
Mr.	Director	-	Usual Residence of Decedent	Jepes 12, 13 21 1.	10d. Inside City Limits
	Aarylan I show	ō	Total States		1 ☐ Yes 21② No
	r 28a-	irect	10e. Street and Number 10f. Zip Code	10g. Citizen of Wh	nat Country?
	eth wit	raiD	1100 Seneca Road 21220	U.S.A.	- American Indian,
9	be filed within 72 hours after deeth with the Maryland that Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes ZXONO Specify:	Rican, etc.) Black Specify:	White, etc.
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	1 and Health am 27 ther tr		Phillip Cunningham (Husband) 1100 Seneca Road, Balt:  20a. Method of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)		tity or Town, State
mor	Pages lent of nt: If it ry or o		1 \( \text{\text{Burial}} \) 2 \( \text{Cremation} \) 3 \( \text{Removal from State} \) 4 \( \text{Donation} \) 5 \( \text{Other (Specify)} \)  Intl Order Of Odd Fell. 3/2!	9/2004 Cowen, W	est Virginia
Baltimore,	permit. Pages 1 and 2 Department of Health a important: If Itam 27 ti any injury or other tra		21. Signature of Funeral Sapries Licensee  22. Name and Address of Facility Bruzdzinsk 1407 Old Eastern Av	i Funeral Home, venue: Essex.	P.A Marvland 21221
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visio	Attend r death ector: / by the f	Certification:	2 Accident investigation  3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number City or Town, State)	or or Rural Route Number,
Ö	ital or ral Dire	Cert	4   Hornicide Building, etc. (Specify)		as stated
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funaral Director: After this certificate he completely filled in by the funeral director, paue	Medical	29a Certifier (Check only one)  29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of the control	ed at the time, date and place, a	nd due to the cause(s)
	To the within 2 To the complete	Me	200.03	•	(Month, Day, Year)
			D 287/7	3.24.	2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR, STephen Selinger TOOO FRANKLIN SENARE DR.	BAITIMERE	1d, 21237
		ate	31. Date filed (Month Cax Year) 2 10 4 32. registrar's Signature		
	Regis	Tal.			

Cunningham

KAREL

			For State Registrar	State of Maryland	d / Depa <i>Ce</i> a	artment of H <i>rtificate of L</i>	ealth and Death		2004	09415
			Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
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	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	h	4c. County of Deat	h
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	Funeral Director		5. Social Security Number 6. Sec 213-36-6863		Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		ear) _ Co	hplace (State or Foreign untry)
	D .		Usual Residence of Decedent  10a, State 10b, County	10c City	, Town or Lo	ocation			- 172	10d. Inside City Limits
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Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funer Service License			. Name and Addres	s of Facility			
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	Physician		shock, or heart failure. List only or Immediate Cause (Final		10					Interval Between Onset and Death
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P.0	hat the	Ph	Part II. Other significant conditions cor	stributing to death but not resu	lting in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
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0			27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injury Work	at ?	28d. Describe how	injury occurred	
Sio	Attending r death. actor: After by the fune	catic	2 Accident investigation			M 1 🗆 Y	′es 2 □No			
) ivi	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At hos building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	a Hospital or At 24 hours after o e Funeral Dirac letely filled in by		29a. Certifier 1 Certifying Phys	sician: To the best of my know	vledge, deat	n occurred at the tim	e, date and place	a, and due to the caus	se(s) and manner as	stated.
	Talha Hospital or Attent Whin 24 hours after death To the Funeral Diractor: completely filled in by the	Medical	(Check only 2 Medical Examination one)	ner: On the basis of examinati and manner stated.	ion and/or in	vestigation, in my op	inion, death occu	irred at the time, date	and place, and due	to the cause(s)
1	To the	Σ	29b. Signature and title of certifier	λ Λ		29c. License			. Date signed (Month	
•	7		- yanishi	whim n	1.0		1809	1	MARCH 23	2004
	5		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	Timo	N NCIC	10 2109	હ
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 2 6 2004	mpleted cause of death (Item 2336 32 Registrar's Signat	ure	WE !				

3/23/04 15:42

Culver, Aubrey

i		1 - For State Registrar	State of Maryl	•	artment of F		Mental Hy	giene Reg. No. 2	004	09416
Physic		Decedent's Name (First, Middle, La     HENRY	CHIN		···		2. Date of De Month March	Day	Year 2004	3. Time of Death
/Med Exam		4a. Fecility Name (If not institution, given 3919 Clarinth Roa	re street and number) ad		Balti		h	4c. Cou	nty of Death A	
Funera Directo			Sex 7. Age (In 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	yrs. last birthday Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs Hours Min.	(Month, Da	ay, Year)	Cou	plece (State or Foreign intry) aryland
Maryland 8-f show	tor	10a. State 10b. County  Maryland N/A		. City, Town or L Baltimor						10d. Inside City Limits 1
paritimities into yield A. I. I. 2000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatte event, the Medical Eventhan Insulate inclined any one injury or other traumatte.	rai Directo	10e. Street and Number 3919 Clarinth Ro	ad 12. Was Decedent Ever	in II C 12	10f. Zip Code  2 Was Decedent of H	1215	inacity Vas or Na		S.A.	
ours after d	by Funeral	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	to Rican, etc.)	Е	Black, White	
within 72 he ene. than "natu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12 years		(Giv	edent's Usual Occup e kind of work done DO NOT use retired Sales	during most of wo	rking		f Business/Ir mobile	
uld be filed Vental Hygi rkad other	To Be Co	17. Father's Name (First, Middle, Las Shew Wing Chin	t)			~1	me <i>(First, Middl</i> e ei Tam			
and 2 sho ealth and I m 27 is me		19a. Informant's Name/Relationship Linda Chin Tom	(sister)	7123	Rivers E				ryland	d 21044
mit. Pages 1 partment of H portant: If ite		20a. Method of Disposition  1 🖾 Burial 2 🗆 Cremation 3 🖟  4 🗎 Donation 5 🗆 Other (Spec	Removal from State	сөтөtөлу, сл orraine	Park Ceme  On Name of Park Ceme  On Name and Address	etery 3-	-27-04	Baltin	nore,	Maryland
Dermi Depar Impo		23a. Part1. Enter the disease, or conshock, or heart failure. List only	enane		22. Name and Addre Mitchell— 6500 York nter the mode of dyin	Road B	altimore	e, Mary	Inc land	21212 Approximate Interval Between Onset and Death
Physiciar /Medica Examine		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cor		/WTox	ICATI	0~			Onset and Death
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events	b. Due to (or as a cor	nsequence of):						
icate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a cor	nsequence of):						
vical necolds, r.O. box o sician: The law requires that the death certificate has been signed by the attending frector, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,			Date of deliv Month	very Day Year
law requires that as been signed by 2 should be deta	þ	Parti. Other significant conditions	-	_	underlying cause giv	en in Part I.	23e. Did 1	2		the cause of death?
The law of the cate has be page 2 she	Completed						1 Yes	psy ormed? 2 \( \sum \) No	prior to co death?	opsy findings available ompletion of cause of
Ol VICAL Physician:   This certifical ral director, p	To Be	25. Was case referred to medical examiner?  1 X Yes 2 \sum No	1	2 ER/Outpatie		er: 4 🗆 Nursing I		idence 6 🟋		ify) at scene
TOTATED TO VICE To Attending Physicien: after death. Director: After this certific in by the funeral director,	Certification:	27. Manner of Death 1 Natural 5 Pending investigating 3 Suicide 6 Could not determine	be 28e. Place of Injury -	At home, farm, s	PM 1	Yes 2 No	28f. Location (	Street and Nu	mber or Run	ral Route Number.
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai Certi		building, etc. (S) hysician: To the best of my iminer: On the basis of exa	knowledge, dea	Home	ne, date and place	RUAD,	SACT:	manner as	stated.
To the H within 24 To the F complete	Medi	29b. Signature and title of certifie	and manner stated.	0. ( (	29c. Licens			29d. Date sig	ned (Month,	, Day, Year)
3	And the second second second second	30. Name appraddress of person who Margarita Korel				oot Pal				
S Regis	tate trar	31 Date filed (Month Day Year)	32. Registrar's 2 6 2004	Signature	Penn Str		canore,	PRILYIA	1AU 212	-UI
DUMU 17 Days	/2004				1					

DHMH 17 Rev 1/2001

**ORIGINAL** 

			Please		nt in Black ir				•	ole.	
			1 - For State Registrar	State of M	aryland / Dep			iental Hyg	giene	001	001.
					Ce	rtificate of	Death			004	
	Physici	an	Decedent's Name (First, Middle, Last	)	D	9		2. Date of Dea Month	_ Day	Year	3. Time of Death
	/Media	cal	Bonifacio		R.	Cast:		March 1			12:25A M
1	Examir	ner	4e. Fecility Name (If not institution, give Southern Maryland			_	or Location of Death		4c. County		
			5. Social Security Number 6. Se		e (In yrs. last birthday	Clinto		8. Date of Birth	Prince		<u> </u>
WH.	Funeral Director			AM 2□F	61 Yrs.	Months Days		8. Date of Birth (Month, Day 06/05/	Year)	Count	ace (State or Foreign try) .lipines
4	- J. Y		Usuel Residence of Decedent					00/03/	1342	<u> </u>	ripines
1	ylan		10a. State 10b. County		10c. City, Town or L	ocation				10	d. Inside City Limits
25.	a-f s	ctor	Maryland Prince Ge	orge's	Ft. Was	shington					1 ☐ Yes X2X No
is	with the Maryland a or 28a-f show be notified at	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of V	/hat Count	ry?
0	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f show ite Madical Examinar must be notified at	ai	3715 Oaklawn Ro	ad		2074	44		USA		
0	be filed within 72 hours after death w tal Hygiene. Ind other than "natural", or Items 23a event, Ite Medical Examinst must	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Blac	e - America k, White, e	
36	s afte	by Fu	1 □ Never Married XXMarried	1 ☐ Yes 2√☐d If Yes, Give	No	1 ☐ Yes 201X No			Specify		.ipino
Ö	72 hours "natural",	d b	3 Widowed 4 Divorced	Year or Dates:	160 800	-death Heart Com					
7 10	n 72 nei	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Dece (Give	edent's Usual Occup  B kind of work done  DO NOT use retire	pation during most of work id)	ing	16b. Kind of Bu	siness/Indi	ustry
32	withi ene. then	mg.	Elementary/Secondary (0-12)	College (1-4or 5	5+)	ntenance	, a,		Postal	Servi	CP
d 2	be filed tal Hygi d other	Ö	17. Father's Name (First, Middle, Last)			in bonding c	18. Mother's Name				CE
an	id be ental ked c	To Be	Jacinto Castro					_		,	
$3\cdot /7\cdot \mathcal{O}\psi$ Maryland 21215-0036	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Ms	-	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mail	ing Address (Street	and Number or Rura	rea Robl al Route Number		State. Zip (	Code)
	and 2:		Alejandra Castro	/ Wife			Road Ft.				,
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If itam 27 sny injury or other tr. once.		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name of	Road It.		20c. Location -		
9	Page: ent o nt: If ry or		1 X Isurial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation \( \sigma \)		St. Mary		I	V1	01.	Taylor o.	CONTRACTOR OF THE PROPERTY OF
重	nit. Pa lartmen lortant: injury io.		21. Signature Funeral Service Licens						Clinton	, lar	yland
B	permit. Departi Import sny inj		Art. Kala	2 1/2,		6160 Over	ess of Facility. Ka n Hill Roa	llas fun	eral Ho	ne P.	A.
	1 4 数		23a. Part. Enter the disease, or compl	ications that caused	the death. Do not en	ter the mode of dyir	ng, such as cardiac of	or respiratory arr	<u>∏IIII. IYl</u> est,		Approximate
	Physician		shock, or heart failure. List only o Immediate Cause (Final		, -		0				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a consequence off:	א משושרי	4 ATRE	(V-			
	Examiner		1	200 10 (0. 20	works to	L. 3.0.	15 ( 05 )		. 1		
		Jer	Sequentially list conditions,	Due to (or as	a sunsequence of).	Atic SMa	The Clark	1000 60	CL ADBAR		
(	an si si si si si si si si si si si si si	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	SMS	1162 110	1415	Ca				
- 3 of	and a series		resulting in death) Last	Due to (or as	a consequence of):		1				
0/7	ysicia ne bu	cai		d							
£ 89	leath certificate attending phys	Jed	IE EE WALE								
T XOX	th cer tendir r use	an/N	230. Was decedent pregnant	3c. If yes, outcome		□Ectopic pregnancy	v			of delivery	
. E	0 0 2	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at 9☐Unknown		Other (specify)	,		Mon	th D	Day Year
20.	at the de I by the a stached	h	9 Unknown								
8,	requires that the een signed by th hould be detache	by Physician/Medi	Part II. Other significant conditions con		ut not resulting in the u	inderlying cause giv	ven in Part I,	11			cause of death?
ord	w requir been s should	ted	Diab	eres.			·	1 🗆 Ye	s 2 No	3 Probat	bly 4 □Unknown
Ö	\$ Q S	pie						24a. Was as autops		ere autops	sy findings available pletion of cause of
- E		Completed						perform	ned? de	eath?	□ No
/ita	Attending Physician: r death. ector; After this certific by the funeral director,	Be (	25. Was case referred to medical examiner?	era Cray			26. Place of Death		-A		
P2	Physic rthis c ral dire	မ	1 195 2 NO	lospital: 1 Inpatie			4 Li Nursing Hor	me 5□Reside	nce 6 Othe	r (Specity)	
7 5	ding P. After t funera	on:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injui (Month, Da)	ry 28b. Time o (Year) Injury	Wor	y at 2 k?	28d. Describe ho	w injury occurre	d	
Sion	death death ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
$\mathcal{ASTRo}$ Division of Vital Records	or Ati	Certification;	4 Homicide determined	28e. Place of Inju	ury - At home, farm, st c. (Specify)	reet, factory, office	2	28f. Location (Sti City or Town		r or Rural I	Route Number,
	Hospital 24 hours a Funeral E				LL - VE-T			and the state of		165	
	Hosp 24 ho Fund felly f	edical	(Check only 2 Medical Exami	ner: On the basis of	of my knowledge, deat examination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	luse(s) and man ate and place, ai	ner as stat nd due to ti	ed. he cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Med	29b. Signature and title of certifier	and manner sta	ned.	29c. Licensi			9d. Date signed		
	1 × 5			351					2   1 ~ 1		
		i					256293	>	711+K	201	
	10	1	30. Name and address of person who co		4	The same of the sa	mp spring	W. n (	12 500		
	Sta	to	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	001	1. 1. N. 16. 16. 2	1777	11 2		
	Registr		MAR 2 6 201		with A	eschi è					

			State of Maryland / Dep 1 - State Amend Item 8 per FH,G830,04/05/04dhbe	artment of Health and Nortificate of Death	1ental Hygi	ene 9. No. 2004 09418
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  Viola M Carter		2. Date of Death Month March 24	Day Year 9:45 a M
	Examir Funeral Director	er	4a. Facility Name (If not institution, give street and number)  2544 Whiteford Road  5. Social Security Number  6. Sex  1 M 2 F 73  Yrs.	4b. City, Town, or Location of Death Whiteford  If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, September	4c. County of Death Harford 1/05/30 9. Birthplace (State or Foreign Country) 5 1930 Parkton, Maryland
	ס	rector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Baltimore Baltimore G  10e. Street and Number			10d. Inside City Limits 1 □ Yes 2 □ No  G. Citizen of What Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23e or 28e-f show eny injury or other treumatic event, Ite Medical Extending to the rutilized at once.	Completed by Funeral Director	65A Calk Grove Road  11. Marital Status  1  Never Married 2 Married 3 Widowed 4 XDivorced  12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	21220  Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 【No Specify:		USA  14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	ad within 72 hou /giene. er then "netura i, it e Medical E	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  VA  (Give life. IV A  Recept:		ng S	Sb. Kind of Business/Industry  Sewing Industry
Maryland	should be fill and Mental Hy s marked oth umatic event	To Be	17. Father's Name (First, Middle, Last)  Stanley Knopp  19a. Informant's Name/Relationship (Type, Print)  19b. Maili		o (First, Middle, Ma Lizabeth G al Route Number, (	ardner
Baltimore, M	Pages 1 and 2 ent of Health and: If item 27 Is		20a. Method of Disposition 20b. Place of Dispo	matory or other place)	Date 20	21220 Oc. Location - City or Town, State
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility ASSAIN Funeral Home Inc 401 Belair Road Baltimo	ore,Maryl <i>a</i> n	d 21236
	Pnysician /Medical Examiner	er	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Under vin.  Due to (or as a consequence of):	/ Mt	, respiratory arres	Interval Between Onset and Death
68760,	es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	edicai Examiner	cause. Enter Under ring. Cause (Disease or injury that initiated events resulting in death) Last  C			
.O. Box	Attending Physicien: The law requires that the death certifica r death. r death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the funeral director.	Completed by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Records, P.	w requires that been signed I should be det	eted by P	Part II. Other significant conditions contributing to death but not resulting in the uniform bocy hem in	nderlying cause given in Part I.	1 ☐ Yes	7 - / -
/ital Re	Physicien: The lav r this certificate has ral director, page 2 a	Be Comp	25. Was case referred to medical examiner?	26. Place of Death		24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
Division of Vital	r Attending Physi er death. rector: After this c by the funeral dire	Certification; To	1   Yes 2   No		ne 5 Residence 28d. Describe how	ee 6 ⊡Other (Specify) injury occurred
N N	in Diffe		29a. Certifier (Check only only only only only only only only	n occurred at the time, date and place a	City or Town, S	ca(s) and manner as stated
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	and mailler stated.			
	6		30. Name and address of person who completed cause of death (Item 23a) (Type,  Michael AUERBRCH, 9/10 Philade)	29c. License number  33557  Print)  Print)  20 # 714	Baltis	n per 2/237
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 6 2004  32. Registrar's Signature	adis .		

State of Maryland / Department of Health and Mental Hygiene 2 19619 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day 2004 Howard Daniels March 24, 10:00 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare - Heritage Center Dundalk Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 29, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 New York **Funeral** 1 □ M 2 □ F 118-09-5042 88 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location in then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director MD. Baltimore 1 ☐ Yes 2√☐ No Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7603 Merritt Point Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. within 72 hours after MYes 2 □ No f Yes, Give Year or Dates: 1 ☐ Never Married 2 🔯 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No <u>م</u> Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 12 years Steel vear 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked o 8 William Daniels Rose Garrett Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health item 27 i Virginia Daniels wife other t 7603 Merritt Point Road, Dundalk, MD. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 26, 20c. Location - City or Town, State Department of H Importent: If its eny injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2004 Dundalk, Md. 21. Signature of Funeral Service <sup>22</sup>Connelly Funeral Home Of Dundalk, P.A. non 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease for complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 3 Probably Completed 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 1 Yes 1 ☐ Yes 2 No 2 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗆 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manns of Death 28b. Time of 28d. Describe how injury occurred Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Hospitel or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14160 OBAIN (HONESSE) (TYPE) Print RITCHLE HIGHWAY MARYLAND 21 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Man	yland / Do	epartme C <i>ertifica</i>	nt of H <i>te of L</i>	ealth a Death	and M		giene 2 Reg. No.	2004	09420
	Div.		1. Decedent's Name (First, Middle, Last	)						2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic		George H. Delano							3	22	2004	4:00 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. Cit	, Town, or	Location o	f Death			ounty of Death	
			5. Social Security Number 6. Se	ARE MAS	h yrs. last birth	day) If Und	1 0 5 e	If Under 2	24 Hrs	9 Date of Dir		AlTin	HORE
	Funeral Director			2□F ('.^9°('	89 YI	Months		Hours	Min.	8. Date of Bir	1914	Çou	place (State or Foreign intry) Tginia
	Q ,		Usual Residence of Decedent									V 1	трина
	arylar show	_	MD Baltimor		Oc. City, Town								10d. Inside City Limits 1 ☐ Yes 2X No
	28e-f	Director	10e. Street and Number	е	Rosed		in Codo				10- 05	4 14/5 -4 00-	
	72 hours after death with the Maryland natural', or Items 23e or 28e-f show dical Exactinate must be notified at	ij	1244 Narcissus Av	renue			ip Code 1237				17	n of What Cou JSA	intry ?
	ms 2;	Funerai	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Dec	edent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		Race - Ameri	
9	or Ita		1 Never Married 2 Married	Armed Forces? ty⊟Yes 2 ☐ No If Yes, Giver J Year or DateWW ☐		1 Tes, sp		n, Mexican, Specify:	, Puerro I	rican, etc.)		Black, White	_
003	urat',	d by	3∕O4Vidowed 4 □ Divorced										hite
15-	in 72	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(	Decedent's Us Give kind of w life. DO NOT	ork done o	lurina most	of working	ng	16b. Kind	of Business/Ir	ndustry
212	d within jiene. r than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		ation :					Allie	ed Chem	ical
b	e filed al Hygi other	Be C	17. Father's Name (First, Middle, Last)	<del>-</del>				18. Mother		(First, Middle			1001
ylai	should bind Ments marked marked	To	Henry Delano					Mart	tha M	laxey			
Maryland 21215-0036	01 40 74 6		19a. Informant's Name/Relationship (7) Ryland Delano	rpe, Print) SON								own, State, Zij ind 212	
	1 and Health am 27 ther t		20a. Method of Disposition		20b. Place of D	Disposition (N	ame of	7		ate		tion - City or To	
nor	Pages nent of int: If its iry or o		1  Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	Garden	crematory or S OT F	other place aith	3	/29/				D 21206
Baltimore,	그 문학급 .		21. Signature of Europa Service Usens	The second secon		22. Name a	ind Addres	s of Facility	Cinol	h/Pogos		uneral	
ä	Depa Impo any is		16			1211 (	Chesa	co Av	enue	Rosec	lale,	MD. 21	237
			23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ications that caused the	e death. Do no								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Renal	FAIL	400						12	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of)	):							
		-	Sequentially list conditions, if any, leading to immediate	b. PACSA		WCER.						-	
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
6	be executed ician and burial-transit		resulting in death) Last	Due to (or as a co	onsequence of)	):			-		-		
8760	cate be executed physician and the burial-transit	Physician/Medical		d,									
9	death certificate e attending phys d for use as the	/Mec	IF FEMALE:	23c. If yes, outcome of p						_			
Вох	atten for us	cian	in the past 12 months?	1 Live birth 2 4 Pregnant at tim	Fetal death	3 ☐Ectopic   5 ☐ Other (s					230	<ol> <li>Date of deliver</li> <li>Month</li> </ol>	ery Day Year
P.0.	the y th	nysid	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	0 01 000111	S Other (s	pocity)						
	law requires that as been signed b 2 should be deta	by Pl	Part II. Other significant conditions con	ntributing to death but n	ot resulting in t	he underlying	cause give	n in Part I.		23e. Did to	obacco use	contribute to ti	he cause of death?
ord	w require been sig should b									10	∕es 2□N	lo 3□Prot	pably 4 Unknown
Vital Records,	e law r has be je 2 sh	Completed								24a. Was	an 2	4b. Were auto	ppsy findings available impletion of cause of
<u>س</u>	The page	Con								perfo	rmed? 2.⊠No	death? 1 ☐ Yes	2□ No
Vita	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	Hospital:			Othe	1000		(Check only o	110000		
o	Phys r this ral dii	. To	1 ☐ Yes 2 No  27. Menner of Death	1 Mnpatient 28a. Date of Injury	2 ER/Outp:		UA J	4 L Nur		se 5 Residente la		Other (Specif	ý)
lon	Attending In death.	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ear) Inju	M M	28c. Injury Work 1 🗌 Y	?` ′es 2 □ N		. 500011001	iow injury or	0001100	
Division of	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm	i, street, facto	ry, office		2	8f. Location (S City or Tox	Street and N	lumber or Rura	al Route Number,
Ö	rs after ral Dire	Cert											
	To the Hospitel or Attending Physician: within 24 hours after deals the Total To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of m ner: On the basis of ex- and magner stated	amination and/o	death occurred or investigatio	d at the time n, in my op	e, date and inion, death	l place, ai h occurre	nd due to the d at the time,	cause(s) and date and pla	d manner as s ace, and due to	tated. the cause(s)
	within To th	Me	29b. Signature and title of certifier	7/1			c. License				2	igned (Month,	
)			March 2	1. 1/0			111	00	-110	,	21	22/	2004
	_		The contract of the contract o				THO	00	16		. ) ]	~ 1 / 1 /	
	M		30. Name and address of person who co	ompleted cause of death	n (Item 23a) (Ty	/pe, Print)	TILO	05	14			2010	2007
	D Sta		30. Name and address of person who co	ompleted cause of death	1000 /-	(pe, Print)	THO	Sour	re l	DR. BA	Tim	ORF 1	2004

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**Physician** 

**Examiner** 

attending physician

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certificete

Diractor: Atter th

within 24 hours To the Funerel

To the Hospitel or Attending Physician:

The law requires that the death certiticate be exec

Division of Vital Records, P.O. Box 68760

Examiner

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/Medical

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Cor	For State of Maryland / Department of Health and Mental Hygiene										
1 - State Registrar			Cei	rtificate of	Death		Reg. No.	2004	091	121	
•	lame (First, Midd					2. Date of De		Voor	3. Time of I	Death	
Willia	m Rando	lph Day				March	20,	2004 Year	2032P.	М	
		on, give street and nu		4b. City, Town, o	Location of Death		4c.	County of Death			
Carrol	l Hospit	tal Center		Westmi	nster		Cá	arroll			
-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)				If Under 24 Hrs. Hours Min.	8. Dete of Bir	place (State or	Foreign			
216 28	6820	1 <b>⊠</b> M 2□F	<b>69</b> Yrs.	Months Days	Tiodis Mini.	10/10/	1934	Balti	more,	MD	
Usual Residence	e of Decedent										
10a. State	10b. Count	у	10c. City, Town or Lo	cation				1	0d. Inside City	y Limits	
MD	Baltir	nore	Baltimore	е					1 X Yes	2 🗆 No	
10e. Street and	Number		10f. Zip Code 10g. Citizen of What					ntry?			

2655 Hafer Street 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ★Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fireman/Plumber Plumbing

17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame

Florence Lumer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Day/Brother 992 Silver Lane, Berkeley Springs, WV 20c. Location - City or Town, State

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 3/23/2004 \*4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, MD

22. Name and Address of Facility Helsley-Johnson Funeral Home 21. Signature of Funeral Service Licensee Inc ahn C Ly 95 Union St., Berkeley Springs, WV 25411-1855 FD#3766R 23a. Part 1, Enter the disease

Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition INA MULTIPLE resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of)

IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1.∠Yes 2 □ No

Year

24a. Was an autopsy performed? 1⊠ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury

1 Natural 5 Pending PEDESTRIAN HIT BY 7 59 P investigation М 1 Yes 2. No 3/20/04 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 140 DENGLAR RD;

Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. March 21, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ,MA ANIT RUBIO

State Registrar

31. Date filed (Month, Day, Year)

1 X Yes 2 No

27 Manner of Death

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 0942

			1 - State Registrar	· · · · · · · · · · · · · · · ·	C	ertificate d	of Death		Reg. No		09422
			1. Decedent's Name (First, Middle, Last	)				2. Date of D	eath		3. Time of Death
	Physici /Medio		Walter Abner	Erdman Jr				MARCH	22	y Year 2004	4:35P. M
	Examir		4a. Fecility Name (If not institution, give	street and number)	······································	4b. City, Tow	n, or Location of Dea	th		. County of Death	
			GOOD SAMARITAN HOS	SPITAL		BALTI	MORE		В	Baltimore	City
	Funeral Director			7. Age (III X 2 F 56	n yrs. last birthda Yrs.	y) If Under 1 Your Months Da	ear If Under 24 Hr ays Hours Mir	s. 8. Date of B (Month, D Februar	irth (ay, Year) Y 23	9. Birthpl 1948 Baltin	lece (State or Foreign try) Ore City, MD
	and * *		Usuel Residence of Decedent  10a. State 10b. County	10	c. City, Town or	Location					Od. Inside City Limits
	Aaryli I sho	ō									1 ☐ Yes 2 ☐ No
	the t	rect	Maryland Baltimore  10e. Street and Number		Baltimore	10f. Zip Coo	te .		10a. Cit	izen of What Coun	trv?
	72 hours after death with the Maryland naturel', or items 23a or 28a-f show dical Examinar must be invilled at	Funeral Director	8623 Heathermill Road			21236			USA		,.
	ms 2	era	11. Marital Status	12. Was Decedent Eve	r in U.S.   13	3. Was Decedent	of Hispanic Origin? (	Specify Yes or N		14. Race - America	
9	or ite	五	1 ☐ Never Married 2 🗶 Married	Armed Forces? 1 ☐ Yes 2 🔀 No			Cuban, Mexican, Pue	to Rican, etc.)		Black, White, e	etc.
93	rei',	i by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>X</b> ☐	No Specity:			Specify: White	е
21215-0036	72 h natu	Completed	15. Decedent's Edu (Specify only highest grad	ication le co <i>mpleted)</i>	(Gi)	edent's Usual Oc ve kind of work of	ne during most of we	orking	16b. K	ind of Business/Ind	ustry
121	within ene. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	_	. DO NOT use re	tired)		A71 /	Nhoust Consists	
	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)		Artis	٥L	18 Mother's Na	me (First, Middl		About Sport	5
ano	d be a	) Be	Walter Abner Erdman Si	-			Juanita I		o, margon	Sumamey	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	은	19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Ma	iling Address (Str	eet and Number or R		ber. City o	or Town, State, Zio	Code)
Ma	ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If item 27 is marked other than "naturel," or items 23s or 28s-1 show or other traumatic event, the Madical Examinar must be notified at		Maurice Erdman (Brothe	er)	1717		treet Owing				,
ē,	s 1 a f Hea item othe		20a. Method of Disposition	2	Ob. Place of Dis	position (Name o	1	Date		ocation - City or Tov	wn, State
E	Page nent c nt: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  1 ☐ Donation 5 ☐ Other (Specify)	Removal from State			March 26 20	04	Balti	more, Mary	land
Baltimore,	permit. Pages 1 and 2 Department of Health ar Important: If item 27 is any Injury or other trau		21. Signature of Funeral Service Licens		50000	22. Name and Ad	Idress of Facility			,	
<b>B</b>	89 = 8		Chatton (10880)	n Chance	Ci !	401 Belai	neral Home I r Road Balti	more, Mar	yland	21236	
*			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	lications that caused the	death. Do not e	nter the mode of	dying, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Meno	scleret	ix land	ioviscula	C DIZE	040	,	Onset and Death
19	/Medical Examiner	Н	resulting in death)	Due to (or as a co	nsequence of):						
100	Lxammer	L	Sequentially list conditions,	b							
	led Isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	risequence oi).						
1	al-trai	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
68760,	ortificate be executed ing physicien and e as the burial-transit			d							
68	ificati g phy as the	Medicai									
Вох	n cert andin use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregna			1	23d. Date of deliver	у
	requires that the death certificate be executed een signed by the attending physicien and nould be detached for use as the burial-transit	Completed by Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time		Other (specify				Month I	Day Year
P.0	at the	Phy	9 Unknown								
	ignec be de	by	Part II. Other significant conditions co-	ntributing to death but no	ot resulting in the	underlying cause	given in Part I.			ise contribute to the	
ord	w require been si should t	ted						10	Yes 2	□No 3 □ Proba	ibly 4/QUnknown
Records,	aw Is b	nple						24a. Was	psy	prior to com	sy findings available inpletion of cause of
H	Th ate pag	Co						1/20 Yes	ormed? 2 □ No	death?	2 □ No
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	tospital:			04	ath (Check only			
of	Phys this al dir	2	1 Yes 2 No   27. Manner of Death	1   Inpatient	2 XER/Outpati	BIIL 3 DOA				6 □Other (Specify)	
uo	ding After funer	tion	1) Selatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) lnjury		njury at Work? □ Yes 2 □ No	28d. Describe	now injury	y occurred	
Division	Attending it death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm, s			28f. Location	Street and	d Number or Rural	Route Number
Div	after Dire	Certification:	4 Homicide determined	building, etc. (S	pecify)	,	-	City or To	wn, State,	)	
	poppite hours nera y fille		29a. Certifier 1 Certifying Phy	sician: To the best of m	y knowledge, dea	ath occurred at the	e time, date and place	a, and due to the	cause(s)	and manner as sta	ited.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2X Medical Exami	ner: On the basis of exa and manner stated.	mination and/or	investigation, in π	y opinion, death occ	urred at the time,	date and	place, and due to	the cause(s)
	Within To t	Σ	29b. Signature and title of certifier			29c. Lic	ense number		29d. Date	e signed (Month, D	ay, Year)
,			1/ Corke	em			C.M.E.		MARC	H 23,2004	1
				empleted cause of death	(Item 23a) (Type		n Street,	Baltimo	ore,	Maryland	21201
2*	Sta Registr	- 4	31. Date filed (Month, Day, Year)	32. Registrarts	Signature	Locale			•		
	.1091311		MAR 2	U LUU4 P SAIGH	State of the	1					

			1 For State	State of Maryland /	Department of Heal		al Hygier	ne 2004	001.22
*	Physici	2.0 2.0	Registrar  1. Decedent's Name (First, Middle, Las	1 1		2. Dat	Reg. I	No. C O O C	3. Time of Death
	/Medio	cal	4a. Fecility Name (If not institution, give		JIKes 4b. City, Town, or Loca		3-22	4c. County of Death	11:50p.M
	Examil	ier	2817 E. Fede	eral Street	Baltin	wore		4c. County of Death	•
5	Funeral Director	1	5. Social Security Number 6. Sec. 30 - 22 - 2159	ex □ M X F 7. Age (In yrs. last I		ours Min. 8. Dat	e of Birth bith, Day, Yea	9. Birthp	place (State or Foreign ntry)
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location			VIII C	Od. Inside City Limits
	the Marylan 28a-f show	Director	MD	Bal	timore				1 Yes 2 □ No
	3a or 2	i Dire	10e. Street and Number 2817 F. Fodos	-al Street	10f. Zip Code		10g. (	Citizen of What Cour	ntry?
	er deatl Items 2	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify Ye exican, Puerto Rican, e	s or No- etc.)	14. Race - Americ Black, White,	
5-0036	172 hours after death with the Maryland *natural', or Items 23a or 28a-1 show cilical Examination to Items at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♥ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Spe	ecify:		Specify: B	lack
215-(	n natu	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	a. Decedent's Usual Occupation (Give kind of work done during life DO NOT use retired)	most of working	16b.	Kind of Business/Inc	dustry
21	Hygiene. Hygiene. Ither than ont, the wes		Elemental/Secondary (0-12)	College (1-4or 5+)	Caterer		Fo	od Se	ruice
land	s should be fited within and Mental Hygiene. Is marked other than aumatic avent, the M	o Be	17. Father's Name (First, Middle, Last)	مرع	18.1	Mother's Name (First,	Pa U	en Sumame)	
Mary	2 8 8 3		19a. Informant's Name/Relationship (7	S ( ) mud to ) 15	9b. Mailing Address (Street and No	umber or Rural Route	Number, City	y or Town, State, Zip	Code)
αĵ	of Health of Health fitem 27 r other tr		20a. Method of Disposition		of Disposition (Name of tery, crematory or other place)	Date	20c.	Location - City or To	wn, State
altimor	Pag nent ant: J		**Burial 2 Cremation 3 :  **4 Donation 5 Other (Specify	Hemoval from State Oil		3/27/0	4 Cr	ewe, Vi	ginia
Ba	permit. 1 Departm Importat any injut		21. Signature of Funeral Service Licen	Irne.	Valid Value of Color Col	TRENC	teure	MD 21	71 CON
	*		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.		4			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SmaC		6struct	ion		DAYS
· 李·蒙	Examiner	je.	Sequentially list conditions,	b. Doe to (or as a consequence	w 0f)				
	nd nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	5 01).				
8760,	be executed sician and burial-transit	cai Ex	resulting in death) Last	Due to (or as a consequence	e of):			10	
89 ×	entificate t ing physic e as the b	edi	IF FEMALE:	0.					
Box	death certific e attending p d for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\sumsymbol{\text{Yes}}\) Yes 2 \(\sumsymbol{\text{No}}\)	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	h 3 Ectopic pregnancy 5 Other (specify)			23d. Date of deliver Month	ry Day Year
P.0	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		9 □ Unknown	9 Unknown			Biston		
rds,	w requires that been signed should be det	ed by	Part II. Other significant conditions co		in the underlying cause given in P	'art I. 23e	1 ☐ Yes 2	use contribute to the	e cause of death?
Seco.	e taw re has bee je 2 sho	Completed	Hyperte	2 ns con		24a	. Was an autopsy	24b. Were autop	sy findings available
	Th ate pag	Ф	25. Was case referred to medical		26 P	1 □	performed? Yes 2 N	death? o 1 ☐ Yes	2□ No
of V	S 5	To B	examiner? 1  Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Outpatient 3 DOA Other: 4	Nursing Home 5	Residence		
	Attending r death. sctor: After by the funer	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Time of Injury at Work?  M 28c. Injury at Work?  1 □ Yes 2		scribe how inju	ury occurred	
	or Atterder after de Directo	ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office	28f. Loca City	ation (Street a or Town, Stat	and Number or Rural te)	Route Number,
1	hours uneral		29a. Certifier Certifying Phy	sicien: To the best of my knowledg	ge, death occurred at the time, date	e and place, and due	to the cause(s	s) and manner as sta	ited.
	To the Hispatiel or Attending Physicial by within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Medicai	29b. Signature and title-of certifier	ner: On the basis of examination as and manner stated.	29c. License numb			ate signed (Month, D	
) ,	3		1 9/ hrs.	hong they.	us 1)252	20	m	Invol 2	13,2004
	0		30. Name and address of person who co	completed cause of death (Item 23a)	(Type, Print) Charles	St. Bola	to me	121208	è
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		-			
DHM	Registra IH 17 Rev 1/20	- 4	MAR 2 6	2004 Jane L	- Book				
				OR	IGINAL				

DHMH 17 Rev 1/2001

25,

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Filipkowski 02:00P M Rubv Elizabeth 2004 March /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 4401 Norfen Road Halethorpe
nder 1 Year | If Under 24 Hrs.
ths Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1□M 2□F 215-14-0239 MD Director 81 Feb 25, 1923 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "netural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be flied within 72 hours after death v Department of Health and Mental Hygiene. I more than 17 the marked other than "netural", or thems 23a any injury or other traumatic event, the Medical E 4401 Norfen Road U.S.A. 21227 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Melvin Middleton Margaret Elizabeth Friedel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Dorothy Filipkowski/Daughter 4401 Norfen Road Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 25 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cementery Brooklyn, MD 4 ☐ Donation 5 ☐ 9ther (Specify) 2004 22 Name and Address of Facility Singleton Funeral Home, P.A. 21. Signal and Funeral Service Consee 1 Second Avenue, S.W. Glen Burnie, MD ere 21061 Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocanellal Inhenition days Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) Yes 2 No page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Proumonia 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3 DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. escribe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 XNatural To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier I Greather Lega WID 127541 Moneh 22, 2004 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4367 Holling fern Rd, Melhinory, MD 21227 CLEETING B A 31. Date filed (All Fragraves) 2004 Defictor's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 09426 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** March 23, 05:40P M 2004 Flanigan Patricia Lynn /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 203 Foxridge Court Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthpface (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**V**□ F 54 219-54-3954 Aug Director MD Usual Residence of Decedent 10d. fnside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code "natural", or Items 23a or U.S.A. 203 Foxridge Court death by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural". or Ihan eny injury or other transmant. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William B. Hughes Sr. Mary A. O'Brian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Lester Flanigan Sr./Husband 203 Foxridge Court Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial Park 2004 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature Funeral Service Licensee Second Avenue, S.W. Glen Burnie, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Finaf disease or condition resulting in death) CANCER OVARIAN **Physician** THREE YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy jo Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 XNo detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 A Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 Tes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 124/2004 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 21 PAUL BALTIMORE 11202 6 2004 32. Registrar's Signature State Registra

			1 - For State Registrar	State of Marylar	nd / Dep <i>Ce</i>	partment of Fertificate of	lealth an Death		Reg. No.	04 09427
	Physici /Medic		1. Decedent's Name (First, Middle, Last	)		Fahe	· V	2. Date of De Month		Year 7 40 A M
- 1	Examir		4a. Facility Name (If not institution, give The Johns Ho 5. Social Security Number 6. S	okins Hos	pital		Location of D	City	4c. County o	N/A 9. Birthplace (State or Foreign
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	Maryland a-f ehow lifed at	tor	10a. State 10b. County MD Baltimo:		Rosec					10d. Inside City Limits 1 □ Yes 2 ☑ No
	with the	i Director	10e. Street and Number 8212 Dorset Avent	ue		10f. Zip Code 2123	7		10g. Citizen of W USA	·
320	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28a-f ehow that the Medical Esantisar must be rediffed at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	J.S. 13	B. Was Decedent of H If Yes, specify Cub	dispanic Origin' an, Mexican, P Specify:	? (Specify Yes or No ruerto Rican, etc.)	14. Race Black	- American Indian, , White, etc. White
1215-0036	within 72 hou ane. Ihan "nature a Medical E	Completed	15. Decedeni's Edu (Specify only highest grad	ucation	- (Giv	cedent's Usual Occup ve kind of work done . DO NOT use retire . Manager	during most of	working	16b. Kind of Bus	
land 2	a ta b	To Be Co	17. Father's Name (First, Middle, Last) Martin Fahey	<u> </u>	rwaze	Tunager		Name (First, Middle get Jordan	, Maiden Surname	
Mary	and and fe m	V 8	19a. Informant's Name/Relationship (7) Maureen Fahey D	<sub>ypo, Print)</sub> aughter	1	iling Address (Street L. Dorset A				
aitimore,	m 0		20a. Method of Disposition  15 Surial 2 □ Cremation 3 □ F  14 □ Donation 5 □ Other (Specify)	20b. Removal from State	Place of Dis cometery, cr rdens	position (Name of rematory or other pla of Faith	ce)   3/	Date 27/2004	Raspeb	City or Town, State urg Md 21206
Pall	permit. Page Department Important: If eny injury or once.		21. Signature of Femeral Service Excens	688	1	22. Name and Addre	ess of Facility C	Vach/Rose	dale Fundale Naryl	eral Home and 21237
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the dealer cause on each line.  a. HYFOXIA  Due to (or as a conse	th. Do not e					Approximate Interval Between Onset and Death Two Houres
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1	law requires that the as been signed by th 2 should be detache	b	Part II. Other significant conditions co	ntributing to death but not re	sulting in the	underlying cause gr	ven in Part I.			bute to the cause of death?
Vital Records,	The ete h page	Completed						1 ☐ Yes	psy pr prmed? de 2 No 1	ere autopsy findings available for to completion of cause of sath?
0	Attending Physicien: Thir death.  •ctor: After this certificete by the funeral director, pag	tion; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death   Natural 5 Pending investigation	Hospital: 2 Inpatient 2 C 28a. Date of Injury (Month, Day Year)	ER/Outpate 28b. Time Injury	of 28c. inju	ner: 4 □ Nursir ry at	Death (Check only of page 1997)  1997  28d. Describe		
Division	9 H 2 E	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		street, factory, office		28f. Location ( City or To	Street and Numbe wn, State)	r or Rural Route Number.
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kn iner: On the basis of examin and manner slated.	owledge, de ation and/or	ath occurred at the ti investigation, in my o	me, date and p opinion, death o	elace, and due to the occurred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
,	To the To the Comp	W	29b. Signature and title of certifier	MD		29c. Licens			29d. Date signed	(Month, Day, Year)
	25		30. Name and address of person who c				DRTH WOL	FE SMEET		MANULAND 21287
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 2.	6 2004 Sign	ature	b d	12: 10 1	1 10		

ORIGINAL

Physici	an	1. Decedent's Name (First, Middle, Las		land / Dep 26/04dhbce					2. Date of De	ath	y 2004 <sup>ear</sup>	3. Time of De 8:30A
/Medic	cal	JOSEPH FELTON  4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	Death	IMICII		. County of Death	
LXaiiii		VA MARYLAND HEALT		117	1	RRY P		A Class	CECIL			
Funeral Director		5. Social Security Number 6. Security Number 218-05-7990		yrs. last birthday) 4 Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Bir JAN	2 2°	1910 C	place (State or Fo WORTH AROLINA
ž.,,		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or L	ocation							10d. Inside City L
a-f sho	tor	MD.		BALTIN	ORE							1 ☑ Yes 2[
s or 28	Completed by Funeral Director	10e. Street and Number 3604 DENNLYN B	OAD		10f. Zip	Code 212	15			•	izen of What Cou	untry?
oms 23	nera	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Dece	dent of Hi	spanic Orig	in? (Spec	cify Yes or No Rican, etc.)	-	14. Race - Amer Black, White	
if, or its	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 Net If Yes, Give Year or Dates: 5 ∕	75#	1 ☐ Yes 46		Specify:					LACK
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Deparament of Health and Menial Hygiene. Important: If item 27 is marked other than "naturat", or ttems 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be nutitied at ance.	To Be Co	17. Father's Name (First, Middle, Last) CALVIN FELTON		1					(First, Middle)			
ith and M 27 is mar r traumati	-	19a. Informant's Name/Relationship (7 LEONE FELTON (			-						or Town, State, Z.	
nent of Health ant: If item 27 a		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State	COb. Place of Dispersion Commetery, cre GARRISC	osition (Nai matory or c N FC	me of other place ORES	•) MAR T VET	e. 3 ERA	ປີ,200 NS CE	4 <sup>20c. Lo</sup> M O	ocation - City or I	own, State
Deparment of Important: If any in ury or once.		21. Signature of Funeral Service Licent			ALVI 412	E. I	s of Setin	UGG	S FUN	ERA	L HOME	npeskovater
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that called the	death. Do not en	ter the mod							Approximate Interval Betwee
ysician		Immediate Cause (Final disease or condition resulting in death)	END STAG	E RENAL D	DISEAS	SE						Onset and Dea 6 MONTH
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been signed b should be deta	d by Pr	Part II. Other significant conditions of SENTLE DEMENTIA	ntributing to death but n	ot resulting in the t	underlying o	cause give	en in Part I.		1			the cause of deat bably 4 🖔 Unki
certificate has bee irector, page 2 sho	Completed by								24a. Was autor perfo		prior to c	opsy findings ava ompletion of caus
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death. ctor: After y the funer	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) Injury	М		k? Yes 2□N	lo				
Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, st Specify)	reet, factor	y, office		2	8f. Location (: City or Tox	Street ar wn, State	nd Number or Ru e)	ral Route Number
within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	sician: To the best of miner: On the basis of exand manner stated	amination and/or in	th occurred evestigation	at the times, in my of	ne, date and pinion, death	place, a	nd due to the d at the time,	cause(s)	) and manner as d place, and due	stated. to the cause(s)
within To th compl	Me	29b. Signature and title of certifier	1 -11	0	29	c. License	number			29d. Da	te signed (Month	, Day, Year)
\		Shen S	7 Ha	Umi	MO	D246	48			M	ARCH 21,	2004
1	[	30. Name and address of person who	ompleted cause of deat	h (Item 23a) (Type	, Print)							

DHMH 17 Rev 1/2001

NAME KNOWN TO PHYSICIAN: FELTON, JOSEPH

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dey **Physician** Edouard Auguste Gauthier March 23, 2004 10:25 P /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pickersgill Baltimore Towson If Under 24 Hrs If Under 1 Year 5. Social Security Number 7. Age (In vrs. lest birthday) 6 Sex 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) Funeral Deys Hours 1₩M 2□ F Months 70 Yrs. Director 371-34-5474 Jul 7, 1933 Canada Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code Funeral 14411 Falls Road 21030 United States 12. Was Decedent Ever in U,S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify. ð 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Teaching Elementary/Secondary (0-12) College (1-4or 5+) Professor of Philosophy 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Donat Auguste Gauthier Jeanne Adele Caldwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Savitri Gauthier/Wife 14411 Falls Road, Cockeysville, MD 21030 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Mar 25 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MOORSY Cremation and Funeral Alternatives 8717 Green Pastures Drive 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 valursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

**Physician** /Medical Examiner physician end s the buriel-trensit or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. s certificete has been si director, pege 2 should After this funeral c n 24 hours efter deeth.

• Funeral Director: Aft To the within 2

with the Marylend

filed within 72 hours efter

permit. Peges 1 and 2 should be filed Depertment of Health and Mental Hygi Important: If item 27 is marked other

Baltimore, Maryland 21215-0020

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r than "natural", or items 23a or 28a-f sho the Medical Evantiner must be notified at

31. Date filed (Month, Day, Year) State Registrar

(Check only one)

le

29b. Signature and title of

and manner steted.

of person who completed cause of death (Item 23e) (Type, Print) 670

w

29c. License number

29d. Date signed (Month, Day, Year)

32

26

₽egistrer's Signature

Amend Item #20b State of Maryland / Department of Health and Mental Hygiene 200 4 Fas Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 4:10am Munch mma 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner BLUE POINT NURSING HOME BALTIMORE N/A If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2√2 F Director 97 06-15-1906 MARYLAND 212-32-6206 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other then "neturel", or Items 23a or 28a-f show ury or other traumatic event, Ite Nedical Experient must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits U Yes 2 □ No Director BALTIMORE MD N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 W. BELVEDERE AVE 21215 USA 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes ♀☐ No
If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK ð 3 √Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELIZABETH JACKSON JOSEPH ANDERSON ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 edmondson ave, baltimore, md CORDELIA JOHNSON, NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3/30/04 Department of I Important: If Ite eny Injury or ot ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State NG MEMORIAL PARK 3/31/04 MARYLAND
LE. Zion
22. Name and Address of Facility HOWELL FUNERAL HOME Donation 5 ☐ Other (Specify) KME. 4600 LIBERTY HGHTS AVE, BALTO, MD 21207 23a. Part1. Enter the disease, or complications that caused the deattf. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ⊋Physician Cardiovascular Disease Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner y physician and as the bunal-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): use as 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 2 should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? has page 2 100 1 ☐ Yes a□NO 1 ☐ Yes certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Medical Certification: To 1 ☐ Yes No 2 ER/Outpetient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28d. Describe how injury occurred after death.

Director: After to in by the funera 5 Pending investigation Natural 2 No 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funerel D 29a. Certifier (Check only one) descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - N 31. Date filed (Month, Day, Year) MAR 2 6 37 Registrar's Signa State MAR 2 Registrar

			For State Registrar	State of Maryla			ent of Hea ate of De		Mental Hy	giene Reg. No. 20	04 09431
100	Physici		1. Decedent's Name (First, Middle, La:	SI) SPANGE	R				2. Date of De.		Year 6:05 A M
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give Union Memos  5. Social Security Number 6. S	estreet and number)  NA HOSPIT  EX 7. Age (in y.)	tal	day) If Un	der 1 Year If	f Under 24 Hrs. Hours Min.	ح	th y, Year)	9. Birthplace (State or Foreign
	yland		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town o				· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
	the Mar 28a-f st	ector	MD W	4	Ba	Itim	Zip Code			10g. Citizen of Wh	1 ☑Yes 2 ☐ No
	23a or	rai Di		Street Apt		ast	212	223			USA
980	, 72 hours after deeth with the Marylan "natural", or Itams 23a or 28a-f show idical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:	U.S.			anic Origin? (S Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		- American Indian, White, etc. BLACK
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or Itams 23e or 28e-f show ha Madical Examiner must be natified as	Completed	15. Decedent's E (Specify only highest gra		(6	Give kind of ife. DO NO	Isual Occupation work done during Tuse retired)	on ing most of wor	king	16b. Kind of Bus	iness/Industry Improvement
	al Hygie d other	Be	17. Father's Name (First, Middle, Last,			r		_		Maiden Sumame,	
Maryland	should be nd Mental marked o	T <sub>O</sub>	Robert Grano  19a. Informant's Name/Relationship		19b. N	Mailing Addr	ess (Street and	RDS I Number or Ru		or, City or Town, Si	tate, Zip Code)
_	of Health a litam 27 is		Daisy Granger  20a. Method of Disposition  1 Burial 2 Cremation 3 E	-/Wife	Place of D	isposition (			Date	20c. Location - C	note MD 21223 lity or Town, State
Baltimore,	permit. Pages Department of I Importent: If its any injury or o		4 Donation 5 Other (Specifical Capacity)	1)	Dud		Pank_ and Address o		-	Baltin ERAL SER	none MD
ä	Depar Impor any ir	N. A	12 and	plications that caused the de	oth Dono	5151	BALTIM	IORE NA	MONALPI	Ke BALTIA	ADDRE MO 21229
	Physician /Medical		23a. Part 1. Ener the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	anni	סאָא נו	/	Such as cardiac	or respiratory ar	rrest,	interval Between Onset and Death
	Examiner	-	Sequentially list conditions,	. CONOMANY	Anna	M/	Umane				INKNOW
o °	eath certificate be executed attending physician and for use as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Substitution of the constitution of the con	CUPID						UNKNOW
58760,	cate be physicie the bu	edicai	•	d							
P.O. Box 6	ath certif attending for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. II yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	etal death	3 ⊟Ectopio 5 ⊟ Other	c pregnancy (specify)			23d. Date Monti	
	w requires that the de been signed by the a should be detached to	by	Part II. Other significant conditions of	contributing to death but not r	esulting in t	he underlyin	g cause given ii	n Part I.	23e. Did to		ute to the cause of death?
Division of Vital Records,	: The law requirate has been page 2 should	Completed								osy pri- rmed? de:	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Zita	/sician: Th s certificate director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:	☐ ER/Outp	atient 3	Othor		th (Check only o	ine) dence 6 □Other	(Specify)
sion of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: T	27. Manner of Death  1 Natural 5 Pending investigation investigation	28a. Date of Injury (Month, Day Year)	28b. Tin	ne of	28c. Injury at Work?			now injury occurred	
ΩĬ	tal or Attender safter deatl	Certific	3 🗍 Suicide 6 🗎 Could not b 4 🗍 Homicide determined		home, larm cify)	i, street, lac	tory, office		28f. Location (S City or Tow	Street and Number vn, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier Check only one) Certifying Ph	nysician: To the best of my kinner: On the basis of exam and manner stated.	nowledge, on ation and/o	death occurr or investigat	ed at the time, of the time, of the time, of the time, ore time, or the time, or the time, or the time, or the time, or th	date and place on, death occu	, and due to the or rred at the time, or	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
1	To the To the Comp	X	29b. Signature and title of certifier	A Por	2.5		29c. License ni AT 24			29d. Date signed (	Month, Day, Year)
	ŋ.		30. Name and address of person who	completed cause of death (I	10 (Ty 10 (Ty 10 (Ty	ype, Print) ST UN	Warsh M	/ panice	m/ 37	innove,	MD 21218
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 6 2004	32. Registrar's Sig			elso.	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) HICKSON Year **Physician** 11:37 PM MARCH JOHN 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Dey. B. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M M 2 □ F 214-50-099 Yrs. 4/ Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 23a or 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 ∑Yes 2 □ No Director more Varyland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or Items 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 ₩Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "ns any injury or other fraumatic event, tra Medic once. Elementary/Secondary (0-12) Coljege (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (daughter) 1008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee W. North Ave. Joseph Baito 23a. Part . Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faillire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) day **Physician** SEPSIS /Medical **Examiner** ntractable Hypotension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ARDS

Due to (or as a consequence of): that initiated events resulting in death) Last the attending physician and Physician/Medical Division of Vital Records, P.O. Box 687 or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be d Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 2 No 1 ¥Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: 1 npatient 2 ER/Outpatient 3 DOA 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier RESOUI 20 04 BALTIMORE who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANOVERST. HOSPITAL Br. SAILATA TUMMALA HARBOR MD 21225 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

			1 - For State Registrar	State of Maryland	d / Department Certificate	of Health and N	Mental Hygiei Reg.	ne 200L	+ 0943;
	Physic		1. Decedent's Name (First, Middle, Last	"Hill = 43			2. Date of Death Month	Day Year	3. Time of Death
	/Med Exami	ner	4a. Fecility Name (If not institution, give  Special  Social Security Number  6. Se	alty Hospit	ast birthday) If Under 1		8. Date of Birth (Month, Day, Ye.	20 2004 4c. County of Death	nplace (State or Foreign
	Director		Usual Residence of Decedent  10a. State 10b. County	10c. City	Yrs. Months L	Days Hours Min.	Dec. 6,	909 100	aryland
	the Marylan r 28a-f show	rector	Maryland NA 10e. Street and Number	R	saltimor		100	Citizen of What Cou	10d. Inside City Limits 1  Yes 2 No
	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Itams 23a or 28a-1 show int. The Modical Examination that the modical Examination or Itams 13a or 28a-1 show int. The Modical Examination or Itams 13a or 28a-1 show int.	Funeral Director		12. Was Decedent Ever in U.S Armed Forces?	2	1215 nt of Hispanic Origin? (Sp Cuban, Mexican, Puerto		14. Race - Ameri Black, White,	A lican Indian,
	21215-0036 Id within 72 hours after designen. Ser than "netural", or Itams It a Medical Examination		1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐	No Specify: Decupation done during most of work	. 16b.	Specify: B	lack
zeneva	nd 2121 e filed within all Hygiene. other than "	Be Completed by	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. DO NOT use i	retired)		Medi	cal
Res	ed al e	To Be	John W. Hi	(Pe, Print) neche w	19b. Mailing Address (S	Mary Street and Number or Parts	E, Sulla Route Number, City	immer	-S
3	C = 0 L		Mr. Ervin Han 20a. Method of Disposition 1 Burial 2 Cremation 3 PR	nilton 20b. Pla	3931 Baca of Disposition (Name metery, crematory or other	areva Re	d. Ba	Location - City or To	121215
至	Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or otha		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Doesse	IVar	yland Na 22. Name and A	thonal 3/30	12004 L	Home	, Md.
			23a. Part/. Enter the disease, or complishock or heart failure. List only or Immediate Cause (Final				or respiratory arrest,	.Md. 212	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque	on's disea ance of):  nellitus	2L			yrs yrs
0	58760, icate be executed physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque					<i></i>
		by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	death 3 □Ectopic pregn			23d. Date of delive	ery Day Year
	cords, P w requires that been signed t should be deta	ed by P	Part II. Other significant conditions con	tributing to death but not result	ting in the underlying cause	e given in Part I.		use contribute to th	ne cause of death?
	Vital Reco	Completed					24a. Was an autopsy performed?	death?	psy findings available mpletion of cause of 2 No
	<b>—</b>	ıtlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No H  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital:     Inpatient   2   EF	8b. Time of 28c. Injury	26. Place of Death Other: 4 Nursing Hon Injury at Work? 1 Yes 2 No		6	()
	Division Attents a attent dead al Diractor ad in by the	Certifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)			8f. Location (Street a City or Town, Stat	nd Number or Rural te)	l Route Number,
	Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification;	one)	ician: To the best of my knowle ner: On the basis of examination and manner stated.	n and/or investigation, in r	my opinion, death occurre	nd due to the cause(s id at the time, date an	s) and manner as stand place, and due to	ated. the cause(s)
•	To To com	2	29b. Signature and title of certifier  Phelifairi		D	3 4 9 7 4		ate signed (Month, D	4
	7		30. Name and address of person who cor	npleted cause of death (Item 2)  D 601, SoufL	3a) (Type, Print) charles S	street, Ro	ltimore	, MDZIZ	230
	Sta Registr		31. Date filed (Month, Day, Year)  MAD 9 6 20	D 601, South 32. Registrar's Signatur	4				

		1 - For State Registrar	State of Maryland	•	nt of Health and te of Death		ene 2004	0 3 1 0 7
Physic		1. Decedent's Name (First, Middle, Las	floman			2. Date of Death Month	Day Year	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, give	street and number)	4b. City	, Town, or Location of De	ath	4c. County of Deatl	h
Funera		5. Social Security Number 6. S	ex 7. Age (In yrs. la	ast birthday) If Unde	1 Year If Under 24 H	rs. 8. Date of Birth	9. Birti	nplace (State or Foreign
Directo		216.12.7729 Usual Residence of Decedent	□ M 2 □ F   98	Yrs. Months	Days Hours Mi	n. (Month, Day, NOV 4, 190		KIE, NC
yland how		10a. State 10b. County	10c. City,	, Town or Location				10d. Inside City Limits
the Ma	Director	MD 10e. Street and Number	BAL	T I MORE	p Code	10	g. Citizen of What Co	1  Yes 2 No
th with 23a or		2700 NORTH CHARLES S	TREET		218		ISA.	
ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland theath and Mental tygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinat must be rediffed at	by Funeral	11. Marital Status  XX Never Married 2  Married 3  Widowed 4  Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 24 No If Yes, Give Year or Dates:	13. Was Dece If Yes, spo	dent of Hispanic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: BLA	e, etc.
5-00	sted t	15. Decedent's Ed (Specify only highest gra	ducation	16a. Decedent's Usi	ual Occupation ork done during most of v		6b. Kind of Business/	Industry
21215-0036 ad within 72 hours af rgiene. er then "naturaf", or t, the Medical Exam.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DOMESTIC HO	ise retired)		PRIVATE HOM	FS
be filed value of other lead	Be Co	17. Father's Name (First, Middle, Last)		DOILLOTTO		ame (First, Middle, M		
Maryland id 2 should be file th and Mental Hy 27 is marked oth	2	WILLIAM HOLLOMAN  19a. Informant's Name/Relationship (	Type Print)	19b. Mailing Addres	MARY ROB		City or Town, State, 2	(ip Code)
Mand 2 shall have all have a 27 is in traus		SHIRLEY_WILLIAMS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ER MARLBORO.	MD 20772	
Baltimore, permit. Pages 1 a Department of Hez Important: If them any injury or otha		20a. Method of Disposition  1XX Burial 2 Cremation 3	Removal from State	ace of Disposition (Na metery, crematory or	me of other place)	Date 2	Oc. Location - City or	Town, State
Baltimor	ė	* 4 □ Donation 5 □ Other (Specifical Service Licer)			nd Address of Facility	17/04 A	HOSKIE, NC	
B Ped B		K. GRECORY FINK		426 CRA	NERAL HOME, P. IN HWY SW GLEN	BURNIE, MD 2	21061	Approximate
Physician /Medica Examine	l r	23a. Part1 Enter the disease, of common shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Reng Due to (or as a consequence)  Due to (or as a consequence)  Due yo (or as a consequence)	Jailur en sic	n			Interval Between Onset and Death
. Box 68760, death certificate be executed e attending physician and ind for use as the burial-transit	dical Examine	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):				
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W 0 - 0	Completed	Concipor	n's	/		24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
of Vital F Physician: Th this certificate ral director, pag	B	25. Was case referred to medical examiner?	Hospital:		0.1	eath (Check only one		
Sion of tending Physicath.  tor: After this the funeral dir	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	OA 4 Nursing 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	9 Home 5 ☐ Resider 28d. Describe hov	nce 6 Other (Spec w injury occurred	ify)
	Certification:	3 Suicide 6 Could not b	e 29 Blace of Injury. At hor	me, farm, street, factor)	ry, office	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	edical C		nysicien: To the best of my knov miner: On the basis of examinati and manner stated.					
To the within 2 To the complet	¥	29b. Signature and title of certifier  Amatun M	Macon MD	2	D / 5503	29	d. Date signed (Month	2, 2004
in		30. Name and address of person who AMATUH HA	JAEEM 50	1 DdPl	inst,B	altimore	MD 213	1
Regis	State strar	31. Date filed (Month, Day, Year) MAR 2 6 200	32. Registrar's Signat	ture				

			1 - State Registrar	State of Mar	yland / Do )	epartmer C <i>ertificat</i>	nt of H	ealth and I Death		iene 20	04	09435
	Physici	an	Decedent's Name (First, Middle, Last						2. Date of Dear		Yeer 121214	3. Time of Death 11:54 DMM
	/Medic Examin	_	Ruth  4a. Facility Name (If not institution, give Saint Joseph		arvey Center	4b. City,	Town, or	Location of Death	1	4c. County of	of Death	more
	Funeral		Social Security Number 6. Se	x 7. Age (	In yrs. last birth	day) If Under		If Under 24 Hrs. Hours Min.				ace (State or Foreign
ł*,.	Director		218-32-0840	□M 2 <b>X</b> )F	85 Y	rs.	Days	Hours Mir.	Sept. 1	3,1918	Mary	
	yland		10a. State 10b. County	1	0c. City, Town	or Location					10	d. Inside City Limits
	8e-f	Director	Maryland Baltimor	e	Ba	ltimore				0-07		1 ☐ Yes 2 <b>X</b> XNo
	with th	Dire	10e. Street and Number 7511 Knollwood	Poad		10t. Zip	Code	286		0g. Citizen of W		r <b>y</b> r
	death	nera	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dece			pecify Yes or No- o Rican, etc.)	14. Race	- America	
36	within 72 hours after death with the Maryland ene. then 'naturel', or Items 23e or 28e-f ehow ta Madical Exerciser musilier notified at	Completed by Funeral	1 Never Married 2 Married  3 Widowed 4 Divorced	1 XYes 2 No If Yes, Give 194 Year or Dates	3-1946	1 ☐ Yes		Specify:	,	Specify:		
21215-0036	72 hour	ted	15. Decedent's Edi (Specify only highest grad	ucation	16a. D	Decedent's Usu Give kind of wo	al Occupa	ition furing most of wor	rkina I	16b. Kind of Bus	siness/Indu	ustry
121	within 7	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT u	se retired)	)		Baltimor Public		•
	Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>		Registe			ne (First, Middle, I			0.10
Maryland	Menta Menta arked atic ev	To B	George E								xley	
Mar	d 2 sho	1	19a. Informant's Name/Relationship (T)						ral Route Number			
	s 1 and Heal		Janis R. Harvey 20a. Method of Disposition	Daughter	20b. Place of D	02 Char Disposition (Nat. Crematory or C	me of	Į.	Luthervi Date	20c. Location - (	City or Tow	1 21093 m, State
Baltimore,	Page ment o ant: If ury or	1	1 X Burial 2 □ Cremation 3 □ I 1 4 □ Donation 5 □ Other (Specify,	)	Memoi	y dal'ie rial Ga	rdens	3-27		Timoniu		Maryland
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 le marked other then "naturel", or Items 23e or 28e-f ehow eny injury or other traumatic event, if a Medical Exercitival manual La rolling at ODCs.		21. Sign Ture Thuner It Service Liden	tagan		22. Name ar 1050		s of Facility  K Road	Ruck Tows Towson,			Home, Inc. 1204
ij.	· 5		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused th	e death. Do no	t enter the mod	de of dying	g, such as cardiac	or respiratory arre	est,	1	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CONGEST			AILL	IRE				Onsol and Doam
Н	Examiner		1	Due to (or as a o	Y ARTE	ERY DI	SEAS	E				
	D is	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of	):						
	al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a c	onsequence of	):						
8760,	ficate be executed physician and s the burial-transit	dical	(	d								
9	sertifica ding ph se as th	/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy					22d Date	of deliver	,
. Box	that the death certif ed by the attending detached for use at	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ( 4 ☐ Pregnant at tin	Fetal death	3 □Ectopic p 5 □ Other (sp				Mon		Day Year
P.0.	at the d by the etache	Phys	9 Unknown	9 Unknown	not requible a in a	de a constant de a		n in Dard I	22a Did to	agent use contril	buta to the	cause of death?
	Se 15 00	by	Part II. Other significant conditions co ACUTE RENAL FAIL	-	tot resulting in t	ne underlying o	ause give	mm Panti.				bly 4 Unknown
Vital Records,	aw requir is been si 2 should I	Completed	DIVERTICULITIS						24a. Was a autops	n 24b. W	ere autops	sy findings available pletion of cause of
= B	The lav	Com							perforr	ned?   de	eath?	
Vita	Physicien: The rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital: 1 Appatient	2 ER/Outp	atient 3 DO	Othe	ACT.	ith (Check only on		s (Sagarhi)	-
Division of	ding Phys  After this funeral di	<b> -</b>	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	28b. Tir		28c. Injury Work		28d. Describe ho			
sior	Attsnding ir death. ector: Afte by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 Y	′es 2□No	28f. Location (St.	root and Numbo	r or Pural	Souto Alumbar
DΪΧ	al or Attsno after deatl Director: d in by the	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (	Specify)	n, street, ractor	у, опісе	_	City or Town		rornurari	noute Number,
	To the Hospital or Attanding Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate h completely filled in by the funeral director, page	edical C		rsician: To the best of r iner: On the basis of ex and manner state	camination and/							
	To the Within To the	Me	29b. Signature and title of certifier			29	c. License	number	2:	9d. Date signed	(Month, D	ay, Year)
)			and	lerge			D 1 Z Z	91		3/2	5/0	, (
1	5+1		30. Name and address of person who c		th (Item 23a) (T 601 05		RIVF	TOWS	ON, MARYI	AND 8	1204	
	Sta		31. Date filed (Month, Day, Year)	\$ 32. Registrar's		a community and	. v met V floore	T tool VV basil la			- and Ter' F	
	Registi	ar	MAR 2 6 2004	Beres &	A 100 4 10							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Bettie Hastings March 2004 0126 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 TF Months 215-16-1507 Director 81 Sept. 28,1922 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 123a or 28a-f show 1 Yes XXNo Anne Arundel Crownsville with the Funeral Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 452 Kyle Road 21032 USA Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2X Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify or than "natural", o þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. 12 Retail Sales 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be August John Henningsen Elsie Lehnert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or other trau once. Dawne Campbell (Granddaughter) 1109 Willowbrook Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Maryland Vet. Cem. 3/26/2004 Crownsville, MD \* 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service P.A. P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or explications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction cute **Physician** resulting in death) /Medical **Examiner** nemia Tronic E squar tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine atheroscherosis rona burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buris Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) the d 9 Unknowf been signed by t should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, plastic 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 XNo 24a. Was an Tension certificate has l irector, page 2 s autopsy performed? res 2 No 1 Yes or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ြ 2 ER/Outpatient 3 DOA this After thi tuneral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director: ,

completely filled in by the t 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the ! 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00 ephen 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) Shan Anne Arunder 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 6 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Month Catherine Fredericka Hallock March 2004 4:00 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Heritage Harbour Health & Rehab. 8. Date of Birth (Month, Dey, Yeer) Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M XXF 97 Director 216-60-5166 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show rthen "natural", or Itema 23a or 28a-f ehov the Madical Examinar must be nutified at 1 Yes XXNo Directo MD Anne Arundel Shady Side 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4885 Idlewilde Road 20764 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. t Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other then eny injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Be Frank Ferdinand Wilde Bertha Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois V. Reed (Daughter) 4885 Idlewilde Road, Shady Side, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Quaker Burial Ground 3/27/2004 4 Donation 5 Other (Specify) Galesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Coronery artes resulting in death) Due to (or as a lon /Medical equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) physician P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown á signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 StNo 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: rector. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 No 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide 1 CCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road #106 odenton MD21113 ell 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 6 2004

			1 - For State Registrar	State of	Maryland		artmen rtificate					giene, Reg. No.	411111	094	39
	Dhysisi	20	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	ath Day	Year	3. Time of 0	Death
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	Examin		4a. Facility Name (If not institution,		,	-			Location	of Death			County of Death		
			Frederick Me: 5. Social Security Number		ospita Age (In yrs. las		Fred		C.K. If Under	24 Hrs.	8 Date of Bir		ederic	K place (State or	Foreign
	Funeral Director		577.34.2174	1 □ M 2 F	75		Months	Days	Hours	Min.	8. Date of Bir (Month, Da June 13		Cou	ntry) Vest Virgin	_
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	how	_	10a. State 10b. County		10c. City,	Town or L	ocation							10d. Inside City	\/
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lary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationshi				-						Town, State, Zi	o Code)	
	1 and Health em 27 ther tr		Mr. Stephen Carna	ahan S	on Place		osition (Nam		snieia C		Columbia, Date		ation - City or T	our Ctoto	
0			20a. Method of Disposition 1 Description 2 Cremation :		ate cen	netery, cre	matory or of	ther place		001	25/2004		Sykesville		1
Baltimore,	그 두 판 등		* 4 □ Donation 5 1 □ Other (Special Signature of Funeral Service Li	-	All C		Crematio			IIC.	20/2001		- Cyncorme	, maryiano	
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			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cau	sed the death.	Do not en						-		Approximate Interval Betw	een
	Physician		Immediate Cause (Final disease or condition		IGHT	51	DED		PNE	eur	non	1		Onset and De	eath
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	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical		Physician: To the be xaminer: On the basi and manner	s of examination										
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	10		30. Name and address of person w	N, 40	DW	7th	STR			RET	ERICK	10	1D 2	1701	
*	Sta Registr		31. Date filed (Month, Day, Year)	R 2 6 2004	istrar's Symatur	ه سی	& A	hood	0						

State of Maryland / Department of Health and Mental Hygiene 200409440 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:50 AM MARCH **Physician** JONES 1 HOMAS /Medical 4c. County of Death or Location of Death Facility Name (If not institution, give street and numb Examiner BATIMORE ILCHRIST Year If Under 24 Hrs. 9. Birthplace (State or Foreign Machine)/LAND If Under 1 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 219.50.0378 Director filed within 72 hours after death with the Maryland Town or Location 10d. Inside Lity Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at BACTIMORE 1 Yes 2 No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number or itema 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 12 2 No Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. econdary (0-12) College (1-4or 5+) LABORER CIOYERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any light or other traumatic event 2008. 17. Father's Name (First, Middle, Last) HOMAS DERTRUDE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type WADE JONES BALTIMORE, MO 21205 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State GARRISON FOREST 4.1.04 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAULITY C. GREENE FUNERIC HONE 21. Signature of Funeral Service Licensee BALTIMORE, MARYLAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cirrhosis End-Stage **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) O 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Ardiomyopath 1 ☐ Yes 2 DeNo 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Func (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 75200 March 24 mo of person who completed cause of death (Item 23a) (Type, Print) Balto, Md N. 32. Redistrar's Signature 6 Contract of the Contract of th Registrar

hysici/ Medio/	an	1. Decedent's Name (First, Middle,		KATHLEEN	JANE	JESENCKY	2. Date of Dear Month	Day	Yeer	3. Time of Death
/ III Care			ANE JESENCE				March			3:55 F
Examin	er	4a. Facility Name (If not institution, g			_	Town, or Location of Dea	ith		inty of Deeth	Country
		742 Weatherbee  5. Social Security Number 6		ge (In yrs. last birthday)	If Under 1	7SON 1 Year   If Under 24 Hr	s. 8. Date of Birth (Month, Day)			County lace (State or Foreitry)
neral ector		140-44-2819 Usual Residence of Decedent	1□ M 2∏ F	54 Yrs.	Months	Days Hours Mir	Mar 18,			Jersey
a a		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limi
event, the Machinal Exercities with the building at	ctor	Maryland   Baltimo	ore County	Tows	รดท					1 ☐ Yes 2 📆 N
	Director	10e. Street and Number			10f. Zip (		1	0g. Citizen o		ntry?
		742 Weatherbee				21286			USA	
	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? d 1 Yes 2 V If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decede If Yes, speci 1 Yes 2	ent of Hispanic Origin? ( Ify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ace - Americ lack, White, cify: Wh	
	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	kind of work	l Occupation k done during most of w		16b. Kind of	Business/Ind	dustry
	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use			Mo	ا موناه	
		17. Father's Name (First, Middle, La	5+	P1	rogram	18 Mother's Na	ame (First, Middle, I		dical	
	Be									
	ပ္	Michael A. Je 19a. Informant's Name/Relationship J.	esencky. Sr	+hom) 19b Mailir	na Address /	(Street and Number or E	Ly Ann B	Lesada City or Tow	m State Zin	Codel
once.		Mr. Michael A. 20a. Method of Disposition	Jesencky, J	Ir. 1151	L. Wood	llane Road,	Art 4D, 1	Mount 20c. Location	Holly,	NJ 08060
		1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe			-	Ch Cem 3/2	27/2004	Pronto	n Mor	Torgon
ė		21. Signature of Funeral Service D	censee	22	2. Name and	Address of Facility				
5000		Martin D. T.	awson	ľ	Mitche	ell-Wiedefel	ld Funeral	l Home	, Inc.	11010
÷		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that cause nly one cause on each l	d the death. Do not ent line.	_			est, Maly	Tanu z	Approximate Interval Between Onset and Death
ı		resulting in death)	- a.	s a consequence of):		<u> </u>				
7	L	Sequentially list conditions,	b							
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence of):						
	al Examiner	that initiated events resulting in death) Last	CDue to (or as	s a consequence of):						
	dical		d	-						
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ≥ 268 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pre				Date of delive Month	ory Day Year
	Phy	Part II. Other significant condition	s contributing to death I	out not resulting in the u	nderlying ca	use given in Part I.	23e. Did tob	pacco use co	ntribute to th	e cause of death?
	by	1		<b>3</b>		given in a constant	T	s 2ÅNo		ably 4 □Unknow
							24a. Was a		. Were auto	osy findings availal
					-		24a. Was a autops perform	y ned?	prior to cor death?	npletion of cause of
	e Completed	25. Was case referred to medical				26. Place of De	24a. Was a autops perform	ned? 2DNo	prior to cor	npletion of cause o
	o Be Completed	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpati	ient 2 ☐ ER/Outpatien	nt 3 DOA		24a. Was an autops perform 1 Yes 2 eath (Check only on	ned? 2 DNo	prior to cor death? 1 ☐ Yes	npletion of cause o
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KURZONTKOWSKI, CARDL Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1-	For State Registrar		ryland / D	Certificate of L	Death		, No. ZUUL	+ 09442
sician		Decedent's Name (First, Middle, La Carol Ann		rzontko	webi		2. Date of Death Month	Day Year 21 2004	3. Time of Death
edical miner		Facility Name (If not institution, given		7 2011 CKO	4b. City, Town, or		1190000	4c County of Dea	
	٨	ORTH ARUNDI		TAL	GIEN If Under 1 Year	BURNI If Under 24 Hrs.	C Date of Birth	HNNE F	HRUNDEL
ral tor	5. 8			(In yrs. last birtl 57 y	rs. Months Days	Hours Min.	8. Date of Birth (Month, Day, ) Oct 11,	1946	thplace (State or Foreign MA
		ual Residence of Decedent  1. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
ral Director		MD Anne An	rundel		Severn				1 □ Yes 2√CXNo
Director	10e	Street and Number 1219 Pine Cone	Count		10f. Zip Code	144	10	g. Citizen of What Co	
Funeral	11.	Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of His If Yes, specify Cubar		ify Yes or No-	14. Race - Ame	erican Indian,
2		1 Never Married 27 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give X Year or Dates:	0	1 ☐ Yes 2 🎝 No	Specify:	ilcan, etc.)	Black, Whit	White
letec		15. Decedent's E (Specify only highest gr	ade completed)		Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired,	lurina most of workin	a	sb. Kind of Business Department	•
Completed	E	Elementary/Secondary (0-12)	College (1-4or 5- 4	+)	Analyst			Defense	
B	17.	Father's Name (First, Middle, Las				18. Mother's Name		uiden Sumame)	
٢		Frank Pestar a. Informant's Name/Relationship		19b.	Mailing Address (Street a	Doris B		City or Town, State,	Zip Code)
		r James R. Kurzo		pouse	1219 Pine 0	Cone Court	Severi		
		a. Method of Disposition 11⊈Burial 2 ☐ Cremation 3 [	Removal from State		Disposition (Name of r, crematory or other place		25	c. Location - City or	
		1 Burial 2 Cremation 3 [ 4 Donation 5 Other (Special Signature Fundation 5 Other (Special Signature Fundation Funda		Maryla	nd Veterans 22. Name and Addres	C E 10'A		ownsville	
	121	The Contract of the Contract o	sex-m	01319	16.	2111		Funeral Ho Burnie, MI	
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	dis	mediate Cause (Final sease or condition sulting in death)	a Angiv	Ration	pulai	now iA	,		Onset and Death
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aminer	Se if a	equentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or injury	Due to (or as a	consequence			, , ,		
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lan/	23	b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 4 Pregnant at	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	livery Day Year
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hy Phy		rt II. Other significant conditions	contributing to death bu	it not resulting in	the underlying cause give	en in Part I.		1	the cause of death?
2	Pal	rt II. Other significant conditions	contributing to death bu	at not resulting in	the underlying cause give	en in Part I.	1 ☐ Yes	2 0 3 □ P	robably 4 Unknown
2	Pal	n II. Other significant conditions	contributing to death bu	it not resulting in	the underlying cause give	en in Part I.	1 Yes	24b. Were all prior to death?	robably 4 Unknown utopsy findings available completion of cause of
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DHMH 17 Rev 1/2001

State Registrar

		•	For State Registrar	State of Mai	-		rtment of H				giene Reg. No. '	200	4 (	09443
			Decedent's Name (First, Middle, Last)							2. Date of De. Month	ath Day	Yeer	3. 1	Time of Death
	Physici		William L.	ouis	Ke1	1ev	Jr.			March	23	200	14	1935 ™
	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City, Town, or	r Location	of Death		4c. C	ounty of Dea	th	
	LXUIIII	<u>.</u>	Anne Arundel Med	ical Cente	r		Annapol	lis			A	nne Ar	unde	1
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last bir	thday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h			State or Foreign
	Director		219-40-1716 <sup>1X</sup>	M 2□ F	60	Yrs.	Months Days	Hours	MIN1.	July 2	3,194	3 Ma	ryla	_
	σ		Usuel Residence of Decedent										104.15	aida Oib I limita
	ylan how		10a, State 10b. County		10c. City, Tow	n or Loc	ation						1	side City Limits ☐ Yes 2 ☑ No
	a-f-a	cto	MD Anne Aru	ındel	Edge	wate	er							
	1 th	ire	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Co	ountry?	
	th wi	a	1391 Nancy Street				2103					USA		
	dea	ner	11. Walital States	<ol><li>Was Decedent Ev Armed Forces?</li></ol>	er in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Or an, Mexica	igin? (Spe n, Puerto	cify Yes or No Rican, etc.)	- 14	Race - Ame Black, Whit		dian,
9	after or it	by Funeral Director	1 Never Married 2 Married	1 ☑XYes 2 ☐ No If Yes, Give		1	□Yes 2 Xwo	Specify	:		s	pecify:	Whi	.te
ğ	ural.	q p	3 Widowed 4 Divorced	Year or Dates:							101 16:	/ Decalars	//	
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7	Athin Pan Man	ш	Elementary/Secondary (0-12)	College (1-4or 5+		rive		2)			Cor	mmerci	<u>.</u> 1	
2	lled v lygie her t	ပိ	17. Father's Name (First, Middle, Last)		עו	TIVE	2.T	18. Moth	er's Name	(First, Middle,			aı	
JUE .	ould be filed within 72 hours after death with the Maryland Mental Hygiene.  arked other than "natural", or Items 23e or 28e-1 ahow attic avant, the Medical Examinar must be notified at	Be	William L. Kelley,	Cr						Hoyer		,		
$\frac{3}{5}$	d Me nark natic	2	19a. Informant's Name/Relationship (Typ		19h	Mailin	g Address (Street				ar City or 1	Town State	Zio Code	a)
Maryland 21215-0036	d 2 sl h an 7 ia r traur		Jean Kelley (Wife)				Nancy St							<i>'</i>
a)	1 and Healt em 2 ther		20a. Method of Disposition	<u>'</u>	20b. Place of	Dispos	sition (Name of			ate		tion - City or	Town, S	itate
ַסַ	ages in it		1 ABurial 2 ☐ Cremation 3 ☐ Re	emoval from State			atory or other plac		2/20	/2004	C	2 1	1 _	MD
altimore,	t. Partmer		*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		Maryl		Vet. Cen			/2004	Cro	wnsvil	ie,	MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ia marked other than "natural", or items 23s or 28s-1 ahow any injury or other traumatic avant, tra Medical Examinat must be notified at once.		13min 2.	Jun-		ob or	Hardesty 12 Ridge	7 Fund	eral venue	, Annar	olis	, MD 2	1401	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused to e cause on each line	ne death. Do	not ente	er the mode of dyin	ng, such as	cardiac o	r respiratory ai	rrest,		Inter	oximate val Between
П	Physician		Immediate Cause (Final disease or condition	KY0	Ke								30	at and Death
*	/Medical		resulting in death)	Due to (or as a	consequence	of):							-	(
350	Examiner		Sequentially list conditions, b											
	n =	ner	Larry, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	of):								
\	cuted	Examiner	that initiated events c.											
ģ	e exe ian a urial-	Ex	resulting in death) Last	Due to (or as a	consequence	of):								
8760,	icate be executed physician and s the burial-transit	dicai	d											
9	ing pl	Med	IF FEMALE:											-
Вох	ith ce tendi	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal death		Ectopic pregnancy	/			23	<li>d. Date of de Month</li>	livery Day	Year
	that the death certiff ed by the attending detached for use as	by Physician/Me	1 Tes 2 No	4☐Pregnant at ti 9☐Unknown	me of death	5 🗆	Other (specify)							
<u>~</u>	d by letach	Phy	Part II. Other significant conditions con	tributing to death but	not cogniting is	n tho un	dodrina causo au	on in Part	1	23a Did to	nhacco use	contribute to	the cau	ise of death?
Ś	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by	Dincreation		-	ii tiio ui	denying cause giv	giriiri girt		121				4 □Unknown
010	requi	Completed	- Partition		<i>Cy</i>									
ec	law lasb	nple								24a. Was autop	sy	prior to	utopsy fir completi	ndings available on of cause of
<u>~</u>	The ate h page	Con								1 ☐ Yes	med? 2 No	death?	2/2/N	Ńo
ita	Physician: this certificatal director, I	Be	25. Was case referred to medical examiner?				Tou		e of Death	(Check only o	ne)			
Ž	hysic his c	2	TO THE ZE NO	ospital: Inpatien		-		4 🗌 N	-	me 5 Resid			cify)	
u u	ng P Viter t	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Injur Wor	k?		28d. Describe I	now injury o	occurred		
Sio	ttendi death. ctor: A y the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2		30/ 1 //	2	N		A- At
Division of Vital Records, P.O.	after d Direct	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	arm, stre	eet, factory, office			28f. Location (S City or Tov		Number or H	urai Houi	re number,
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only 2 Medicel Exemin	er: On the basis of e	xamination an									cause(s)
	the I	Medicai	29b. Signature and title of certifier	and manner state	ed.		29c. Licens	e number			29d. Date	signed (Mont	h, Dav.	Year)
	T Wil		DI M W	7			Done	1130	1		Ma	2/2	266	2010
	nn		4 11			(T) := 1	2::0)				1. 10(1	001	17	0003
	70		30. Name and address of person who con	MV	900 B		gate for	ad 50	THE 3	00 Av	ngpo	lis No	10 2	1401
-	Sta Regist	_	31. Date filed (Month, Day, Year) MAR 2 6 200	32. Registrar	•	4	Some	1	-W		7	,		

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.

	1	For State Registrar			State o	of Mary			artmen tificate				fental Hyg	jiene	004	. 09441
Physician /Medical Examiner		1. Decedent's Name  HOWARD  4a. Facility Name (III	)	MARK n, give st		LESSI	ER		1.5		Location of		2. Date of Dea Month MARCH	Day 20 4c. Co	Yeer 2 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4 11-00 HM
Funeral Director	3	5. Social Security No. 215-62-724	umber	6. Sex	M 2   F		n yrs. last birth	rs.	If Under Months		If Under Hours		8. Date of Birth (Month, Day JULY 8,	Year)	9. Bi	inthplace (State or Foreign Country)
Maryland f show ied at		Usual Residence of 10a. State MD	Decedent 10b. County ANNE		EL	10	Oc. City, Town									10d. Inside City Limits
death with the Maryland ms 23e or 28s-1 show rmust be notified at		10e. Street and Nun		нісн	VAV	*			10f. Zip	Code 21061				IOg. Citizer	n of What C	Country?
"natural", or its		11. Marital Status  XX Never Marri 3 Widowed  (Spec	ed 2 Mar 4 Divorced 15. Deceder	nied it	2. Was Dec Armed F 1  Yes If Yes, G Year or D ation completed)	orces? 2 (X)(0 orive Dates:	16a. C	Deced	Vas Deced	lent of Hi ify Cuba EXNO	Specify:	i, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Am Black, Wh pecify: of Business	WHITE
		Elementary/Secon 12 17. Father's Name (	First, Middle	Last)	College (	(1·4or 5+)	1	NUTO	MOBILE	DETA		er's Name	e (First, Middle,		TOMOBIL mame)	ES
id 2 should be filter and Mental Hy 77 is marked oth 17 one		HENRTY LE  19a. Informant's Na  BETTY LE	me/Relation		-						and Numbe		RRIS al Route Number T 207, SII			
Dermit. Pages 1 and 2 Department of Health mportant: If item 27 in highly or other france.	-	20a. Method of Disp 1 Durial 2X	osition XCremation	3			20b. Place of D	Dispo:	sition (Nam	ne of ther place	9)		Date	20c. Locat	ion - City o	r Town, State
permit. Page Department o Important: If any injury or once.		21. Signature of Fur	neral Service	0	1	101148	1	22	. Name and				INK FUNERA			51
cate be executed hydrician and the burial-transit que burial-transit physician and the burial-transit que and the purial-transit que and the purial-transit que and the physician and the physic		23a. Part1. Enter it shock, o'hlear Immediate Cause (disease or condition resulting in death)  Sequentially list confirmant, leading to imcause. Enter Under Cause (Disease or that initiated events resulting in death) L	nt failure. Lis Final n inditions, imediate rhying injury	a. b. c.	Due to	each line.  EP  (or as a co		). //,		5 Or Gymig	, such as	Cardiac	n respiratory arr	est,		Approximate Interval Between Onset and Death IODAYS
death certific e attending p d for use as		IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23		birth 2 nant at time	Fetal death		Ectopic pre					23d	Date of de Month	elivery Day Year
The law requires that the drawn ten has been signed by the bage 2 should be detached completed by Physic		Part II. Other signifi ACQUIR					ot resulting in t				n in Part I. D Ro			pacco use		o the cause of death?
ician: The law rector, page 2 sh		25. Was case referr												ned?	4b. Were a prior to death?	utopsy findings available completion of cause of s 2 No
Physician: This certific ral director.	-	25. Was case referr examiner? 1 \sum Yes 2 \sum 4	Мо			Inpatient	2 ER/Outp				E 4□Nu	rsing Ho	n <i>Check on on</i> me 5 ☐ Reside	nce 6		ecify)
Attending r death. Attending by the fune ification		1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pendi	gation not be	28e. Place	of Injury oth, Day Ye e of Injury ling, etc. (S	- At home, farn	ury	М		at ? ′es 2 □ I	No	28d. Describe ho 28f. Location (St City or Town	reet and N		ural Route Number,
ne Hospital or n 24 hours atte he Funeral Dirr pletely filled in I		29a. Certifier (Check only one)	1 Certifyi	ng Physi Examine	r: On the b	e best of moasis of exa	amination and/	death or inv	occurred a estigation,	it the time in my op	e, date an inion, deal	d place, a	and due to the ca	ause(s) and ate and pla	d manner as	s stated. a to the cause(s)
To the comple		29b. Signature and			Yan		2,	. ~	0	License	+ 6	96	2 1	MAR	CH	th. Day, Year) 20, 2004
			RAZI	, M.	D.	Noi	RTH	A	Run	DE	L	Ho.	SPITA	L , .	MD ?	21061,
State Registrar		31. Date filed (Mont	2 6 200	4	32. F	Registrar's	Signature	Se.	,							

		•	1 - For State Registrar	State of Man		artment of		nd Mental H	ygiene Reg. No. 20	04 09446
	Physicia	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of D Month 03	Day	Year 7:30 AM M
П	/Medic	al	Doris Ione Lilly  4e. Fecility Name (If not institution, give	street and number)		4b. City, Town	n, or Location of		4c. County of	
	Examin	er	Genesis Franklin				imore		Balti	imore
	Funeral		5. Social Security Number 6. Se	7. Age (l	n yrs. last birthday,		ar If Under 2	Min. (Month, E	irth Day, Year)	Birthplace (State or Foreign Country)
	Director		579-34-6482	□M 2 <b>X</b> )F	78 Yrs.		,,,	03/15/	1926	Maryland
	and	}	Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits
	Maryl f sho	jo	MD Harford	1	Joppa					1 ☐ Yes 2X No
	deeth with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number			10f. Zip Cod	le		10g. Citizen of W	hat Country?
	th wit		511 K Cider Pres	ss Court		210			U.S.A.	
	tems terms	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Race Black	- Americen Indian, c, White, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 □ Yes 2 <b>X</b> I	No Specify:		Specify:	White
21215-0036	within 72 hours after ene. than "natural", or ite na Medical Examina	ted t	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Oc	cupation	-1	16b. Kind of Bus	
215	hin 72 Pn "na Media	ple	(Specify only highest gra-	de completed)  College (1-4or 5+)	life.	kind of work do DO NOT use re	ine during most tired)	of working		
N	filed wit Hygien ther the	Completed	12	3	Reg	istered		4. Al		Gen. Hospital
ind	be fill stal H od oth	Be	17. Father's Name (First, Middle, Last)					's Name (First, Middi	e, Maiden Sumame	))
Maryland	s 1 and 2 should be filed within 72 hours after deeth with the Marylan Health and Mental Hygiene. Health and Mental Hygiene the file 23 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked than Medical Examinar must be multihed at	ဥ	James Thomas Bow 19a. Informant's Name/Relationship (7		19b. Mail	ing Address (Str		ola Lyon r or Rural Route Num	ber. City or Town, S	State, Zip Code)
<u>S</u>	nd 2 salth an 27 ls r		Diana Lassahn	<i>ypo,</i> ,				Court - Jo		21085
e,	s 1 and of Health item 27 other to		20a. Method of Disposition	1	20b. Place of Disp		1	Date		City or Town, State
altimore,	0 0		1 X Burial 2 ☐ Cremation 3 ☐  1 4 ☐ Donation 5 ☐ Other (Specify					3/27/2004	LaPlat	a, Maryland
Balti	permit. Pag Department Important: I sny injury o once.		21. Signature of Funeral Service Licen	See				E. F. Las oad - King		eral Home, P.A. ID 21087
4.	100		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.					arrest,	Approximate Interval Between Onset and Death
760,7	Physician /Medical Examiner  per partial-transit properties of the	icai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter 'Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c		3r terr	J.S.	tion isease		
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 [ 4 Pregnant at tin 9 Unknown	Fetal death 3	□Ectopic pregna □ Other (specify			23d. Date Mon	e of delivery th Day Year
٥.	uires that I n signed by uld be deta	ρ	Part II. Other significant conditions of		not resulting in the	underlying cause	given in Part I.	1		ibute to the cause of death?  3 Unknown
Vital Records,	Physician: The law requir r this certificate has been si ral director, page 2 should I	Completed	1 3					24a. We aut per	opsy formed? d	Vere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2☐ No
ita	stan: artifica ctor, p	Bec	25. Was case referred to medical examiner?					of Death (Check only		
of <	Physician: r this certific ral director,	ဥ	1 ☐ Yes 2 ☐ Go	Hospital: 1 ☐ Inpatient		nt 3 DOA		rsing Home 5 Re		
on c	ling P	ion:	27. Manner of Death  1 SNatural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time (	1	Injury at <b>*</b> Work? 1 ∐ Yes 2 ∐ N		e how injury occurre	D
Division	Attending in death. sector: After by the fune	Certification:	€ Accident Investigation 3 Suicide 6 Could not be determined	e 28e. Place of Injury	- At home, farm, s			28f. Location		er or Rural Route Number,
ă	atter I Dire	erti	4 Homicide	building, etc. (	Specify)			City or 1	own, State)	
	To the Hospital or Attending is within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical (		nysician: To the best of n niner: On the basis of en and manner state	camination and/or i					
	To the To the complete	ž	29b. Signature and title dispertifier				ense number			(Month, Day, Year)
	05		, Mr		MD		DZS	794	3/23	10/04
_	7		30. Name and address of erson who  Soe Muneses  31. Date filed (Month, Day, 1987)	_	7845	Opku	bood	Road	Glen B	ploy 21061 Whie, MD
	Sta Regist	ate rar	MAR 2 6	M.	c &	horis				

			<b>1 - State</b> Ragistrar	estates504/	28/04 Leps Cei	artment of H	lealth ar Death		giene2 0 0 4	09447
			1. Decedent's Name (First, Middle, Last,	)				2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Madge Carroll Lea	ader				March	16 2004	9:30 P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of E	Death	4c. County of Death	1
			Calvert Manor Hea			Rising			Cecil	
	Funeral		5. Social Security Number 6. Sec	x 7.Age( ∃M 2√2 F	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Min (Month, Day	Year) Col	nplace (State or Foreign untry) L WV
	Director		222 12 1000	3. X.	101 Yrs.			Septemb	et 18, 2004	L WV
	and W		Usual Residence of Decedent  10a. State 10b. County	1	IOc. City, Town or Lo	cation				10d. Inside City Limits
	Aarylt Sho	ō	MD Cecil		Rising:	Sun				1 ☐ Yes 2 No
	the 1	Director	10e, Street and Number		Recovery .	10f. Zip Code		1	log. Citizen of What Co	untry?
	With 3a or		1881 Telegraph Re	oad		21911			USA	
	death The 2	Funerai	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.		ispanic Origin	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White	
ی	ours after death with the Marylan rel', or Items 23a or 28a-1 show Examiner must be molified at	Ξ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give		1 ☐ Yes 2 🕱 No	Specify:	gerto riican, etc./		
9	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show edical Examiner must be mulified at	þ	3 X Widowed 4 ☐ Divorced	Year or Dates:		1 1 1 63 2 ДД 110	opecity.		Wil	ite
5-0	72 h natu	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done	during most o	f working	16b. Kind of Business/I	ndustry
2	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	<del>2</del> )		Public Sc	10000
2	filed within Hygiene. sther than "		17. Father's Name (First, Middle, Last)	4	100	icher	18. Mother's	Name (First, Middle,		.noox
anc	htal H	Be	John Carroll					lie Eden	,	
Ž	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ira M.	၉	19a, Informant's Name/Relationship (T)	voe. Print)	19b. Maili	ng Address (Street			r, City or Town, State, Z	ip Code)
=	d 2 s th an th an trau trau		Richard Leader/S		150	) Knollwo	od Roa	d, Elkton,	MD 21921	
စ်	pas 1 and 2 should be filed within 72 ho of thealth and Mental Hygiene. If Item 27 is marked other than "natur or other traumatic event, Ira Madical		20a. Method of Disposition		20b. Place of Dispo			3-18-2004	20c. Location - City or	Fown, State
JO T	0 0		1 🔀 Burial 2 💢 Cremation 3 □ F  ` 4 □ Donation 5 □ Other (Specify)	Removal from State		rd Funera			Rising Sun	, MD
	그 돈 뿐 글		21. Signature Funeral Service Licens						Funeral Ho	
ä	Departing any is		Luchard of	Clor	410	111 S. Yu	een Si	reei, kisi	ng Sun, mv	21911
			23a. Part . Enter the disease, or comp shock, or heart failure. List only o	lications that caused the	ne death. Do not en	er the mode of dyin	ng, such as ca	rdiac or respiratory arr	est,	Approximate Interval Between
	Physician	.	Immediate Cause (Final disease or condition	U Co	ona estiva		I Transmit	atlute		Onset and Death
1	/Medical		resulting in death)	Due to (or as a	consequence of):					
1	Examiner			b	Α.					
1	pe is	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
V	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
8760	be ey ician buria									
687	phys phys s the	dicai		d						
×	certif nding use as	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		-			23d. Date of deli	very
Вох	death atter	ciar	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2 4□Pregnant at ti		]Ectopic pregnancy ] Other (specify) _	/ 		Month	Day Year
P.0.	that the death cer ed by the attendin detached for use	hys	9 Unknown	9□ Unknown						
٦,	signed by det	by Physician/Me	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	
rg	w require been sig should b	edt	Ven Ven	recitio				_ ¹□Y	es 2□No 3□Pro	bably 4 Unknown
SCO	aw requis been 2 should	Completed	Hypo	othy norda	SM			24a. Was a	an 24b. Were au	topsy findings available completion of cause of
Œ.	The late has bage	E O		Ü				perfor 1 ☐ Yes	med? death? 2☑No 1☐Yes	2□ No
ita	ian; ortifica ctor,	Be	25. Was case referred to medical examiner?					Death (Check only or	19)	
of Vital Records,	Physician; this certific ral director,	2	1 Tyes 2 No	Hospital: 1   Inpatient	the state of the s		4 _ Nurs		ence 6 Other (Spec	cify)
u o	ng Pl	ü	27. Man or of Death 1 ∠ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	rk?		ow injury occurred	
sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	Di Di di Ciri	A1 h =		Yes 2 □ No		treet and Number or Ru	ral Route Number
Division	al or At after d Direct d in by	Certification;	4 Homicide determined	building, etc.	y - At home, farm, st (Specify)	eet, factory, office		City or Tow	n, State)	12.71001011011001,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phy	/sician: To the hest of	my knowledne, deat	h occurred at the tir	me, date and	place, and due to the o	ause(s) and manner as	stated.
	24 hc 24 hc Fun etely	Medical	(Check only 2 Medical Exam	iner: On the basis of e and manner state	examination and/or in	vestigation, in my o	ppinion, death	occurred at the time, o	late and place, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	A =		29c. Licens			29d. Date signed (Month	. /
	->-0		1 Leehu	4		D	005	8904	3/17/	7007
	10		30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (Type,	Print)			F1 - 1	Grace MD
_	10		Ha J	Lee, M	.D. 310	1 2 M	non,	Avenue	Maure de	Grace, MV
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar	Set	back s				7

Physicia	•	Registrar  1. Decedent's Name (First, Middle, Last)  Martha Patricia	Moore				2. Date of I	Death Day	2004	3. Time of Death
/Medica	ıl.				4h City To	wn, or Location o	Marc		Dunty of Death	1240p
Examine		4a. Facility Name (If not institution, give s Maryland Gene	eraj Ho		Bal-	Himore				
Funeral Director		5. Sociat-Security Number 6. Sex 1□ 227-26-9097	M 2XIF	(III yrs. last birthda Yrs	Months   E	Year If Under a Days Hours	8. Date of E (Month, 103/04)		9. Birthpl Count Virgi	
2 3		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					Od. Inside City Limits
a-f sho	ctor	Maryland		Baltimor	e					1 XYes 2 No
injed within 7.5 hours after bean with the Maryland Hygiene.  Wher then "natural", or Itams 23e or 28e-f show  ont, the Medical Ever it wir mail be notified at	Dire	740 Poplar Grove S	Street		10f. Zip Co	ode 1216		10g. Citizer	n of What Count	try?
ems 23	Funeral	740 Popular Crove	12. Was Decedent E Armed Forces?	ver in U.S. 1			gin? (Specify Yes or ! , Puerto Rican, etc.)	1	Race - America Black, White, e	
"natural, or itams 23e or 28e-f show edical Exaction result be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X N If Yes, Give Year or Dates:		1 ☐ Yes 🏋				pecify: Blac	:k
dical E	eted	15. Decedent's Educ (Specify only highest grade		16a. De	icedent's Usual C	Occupation done during most retired)	of working	16b. Kind	of Business/Ind	lustry
De M	Completed	Elementary/Secondary (0-12) 4	College (1-4or 5-	+)	sekeeper			Domes	stic	
5 5	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Midd	le, Maiden Su	imame)	
marked o	2	Eddie Brickley  19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Ma	ailing Address (S		Williams r or Rural Route Nun	ber, City or To	own, State, Zip	Code)
item 27 is marke other traumatic		Renay Williams / G	randdaugh				St., Balti	-		21216
= 5		20a. Method of Disposition  TX☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	1	crematory or othe	r place)	Date 3/27/2004		tion - City or To	
important: I		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		Woodlaw	22. Name and	Address of Facility	The Derri	ck C.	Jones F	/H, P.A.
eny ir		Deud !	· Kom				Ave., Bal		, Maryla	
sician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	( )	the death. Do not e.	onter the mode of	or dying, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
dical niner		resulting in death)	1	consequence of):	Ca	ncer	_			
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a	outplence of):	0 00	an ex				
l-transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):						
	dicai E		I							
as th	Med	IF FEMALE:	3c. If yes, outcome of	of pregnancy		· · · · · · · · · · · · · · · · · · ·		224	d. Date of deliver	
di di	嵩	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant at	2 🗍 Fetal déath	_			. 230		Day Year
e attendin	0	10163 2010		time of death	3 □Ectopic preg 5 □ Other (spec	rfy)				
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ORIGINAL

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Physician		Decedent's Name (First, M	iddle, Last)			McALLIS	eten.				Date of De Month	Da		Year	3. Time of D	М
/Medical	1	PATRICIA  4a. Facility Name (If not institu	ution, give :	ANN street and num	ber)	MCALLI		Town, or	Location of E		arch		2004 c. County o		8:40	A '''
Examiner		Greater Balti				ter	Tows						altim			
Funeral		5. Social Security Number	6. Sex	ζ 7		rs. last birthday,		1 Year	If Under 24 Hours	Hrs. 8. (	Date of Bir Month, Da	th			place (State or F	Foreign
Director	-	145-34-8697		м 2 <b>XX</b>	60	Yrs.					ARCH 2				GÉTON, NJ	<u> </u>
T) land	- 1	Usual Residence of Decedent 10a. State 10b. Cou			10c.	City, Town or L	ocation							1	0d. Inside City	Limits
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16 after death w or liteme 23e		<ol> <li>Marital Status</li> <li>Never Married 2 (X)</li> </ol>		12. Was Deced Armed Ford 1 Tyes 2	ces?	10.5.	If Yes, spe	cify Cuba	ispanic Origin In, Mexican, P	uerto Rica	in, etc.)			, White,		
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Taryla 2 should and Men Is marke aumatic		19a. Informant's Name/Relate					•		and Number o				or Town, S	tate, Zip	Code)	
e, N t and tealth ther tu	-	GARY LEE McAL 20a. Method of Disposition	LISTER	, SR.	201				MONKTON,	Data	LAND 2		_ocation - C	ity or To	wn State	
Baltimore, Mapermit. Pages 1 and 2 Department of Health a Important: If them 27 is any injury or other transpace.		1 Øy8urial 2 ☐ Cremati	on 3 XX	Removal from S	late	cemetery, cre			(e)	5						
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Bal permi Depa Impo Impo		KELLY OREC	ORY FT	DE CLIMO	1148	4	26 CRA	IN HI	CHWAY S.						061	
Physician /Medical Examiner		23a. Paril. Enter the dishase shock, or heart failure. Immediate Cause (Final disease of condition resulting in death)  Sequentially list conditions, if any, leading to immediate.	List only or	Due to (c	or as cons	eath. Do not en	*	le of dyin	g, such as car	rdiac or res	spiratory a	rrest,			Approximate Interval Betwe Onset and De	
68760, rifficate be executed by physician and as the burial-transit	2	cause. Enter Underlying Cause (Cause or Injury that indiated events resulting in death) Last			or as a cons	sequence of):										
Division of Vital Records, P.O. Box 68 of or Attanding Physician: The law requires that the death certificat after death.  Director: After this certificate has been signed by the attending phy tin by the funeral director, page 2 should be detached for use as the partition of the formulated by Physician/Median	I ysicialium	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐No 9 ☐ Unknown	2	3c. If yes, outc 1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknow	th 2 Fi	etal death 3[	⊒Ectopic p ⊒ Other (sp						23d. Date Mont		ery Day Yea	ar
ords, Paquires that en signed I build be det	2	Part II. Other significant con	ditions cor	ntributing to dea	ath but not r	resulting in the u	underlying o	ause giv	en in Part I.	_ [		obacco Yes 2		oute to th	ne cause of dea	
on of Vital Record ding Physician: The law requir h. Atter this certificate has been si funeral director, page 2 should floor. To Re Completed	online									-	24a. Was autor perfo 1 ☐ Yes		pri	or to cor	psy findings avan pletion of cause 2 No	allable se of
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Division Create Hospital or Attending P Whin 24 hours after death. To the Funeral Director: Attent completely filled in by the funeral Mardical Certification.	Sel mice	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e. Place o buildin	of Injury - Al g, etc. <i>(Spe</i>	t home, farm, st	reet, factor	y, office			Location (S City or Tox			or Rura	il Route Numbe	ır,
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To all		29b. Signature and title of cer	trier	jus	m.	حد	29	c. License	number	96	7	29d. Da	ate signéd	Month C	Day, Year)	
		30. Name and address of per	son who co	on beted cause	of death (I	tem 23a) (Type	, Print)		1	P	1			7	2 . 4	
State	0	31. Date filed (Month Day, Y	9ar) C		D / O	gnature	Ch.	27/	es 57	Dq	/Tibn-	-1 1	カン	21-	201-	
State Registrar		,	2004	S. Carlo	, St	gnature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 09450 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 21, 2004 **Physician** VIRGINIA MULLINS 4:00 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHESAPEAKE HOSPICE HOUSE LINTHICUM ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 11/137 1912 ear) VIRCTRYA 1 M 200 F 91 Director 216-32-0637 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No LINTHICUM Director ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21090 539 PRITCHARD DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 KNO 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2XX No Specify: Specify: \$ 3 (Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a Mississian in the Mis Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lauuna Beverly Emory Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 413 LIGHT STREET, KINGSPORT, TN 37663 WILMA GRAHAM DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Xxurial 2 □ Cremation 3 □ Removal from State **GLEN HAVEN MEMORIAL PK** 3/25/2004 GLEN BURNIE, MD 21. Signatury Funeral Service License 22. Name and Address of Facility FINK FUNERAL HOME, PA MCOU 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 #M01148 KELLY GREGORY FANK 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran and Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ţ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 11No 1 Yes 2 No 1 Tyes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) MOJOICE examiner' Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 104 C 28a. Date ol Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural 5 Pending м 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State

Registrar

With

death

within 72 hours after

certificate be executed

Box 68760.

P.0.

Records.

Division of Vital

Baltimore, Maryland 21215-0036

Hospital Drive 31. Date filed (Month, Oay, Year) MAR 2 6 2004

29a. Certifier

(Check only опе)

29b. Signature and title of certifier

Medical



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Gien Burnie md 21061

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2001 09451 1 - For State Registra Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** 10:15 P M Mebane Richard March 2004 Walter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glen Burnie Anne Arundel North Arundel Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sep 23, 192 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 240-38-7704 76 NC Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State id other than "natural", or items 23a or 28a-f show event, the Medical Examples inval be notified at 1 Yes 2 No Glen Burnie MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21060 108 Juniper Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s sny injury or other traumatic event, the Medical Exame as most Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∰Yes 2 □ No 51 - 71 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S. Army Lieutenant Colonel 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arthur F. Mebane Fannie Pinnix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Juniper Drive Glen Burnie, MD Mrs. Gracie B. Mebane / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place) | March 26 Maryland Veterans Cemetery 2004 1 Denial 2 □ Cremation 3 □ Removal from State
4 □ Denation 5 □ Other (Specify) Crownsville, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. Fral Service Licensee 21. Signa ure Second Avenue, S.W. Glen Burnie, MD mo1120 Pant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit 0 and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physicien Physiclan/Medical the IF FEMALE: nse nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 21X No 1 ☐ Yes 2 No 1 Tyes Hospitel or Attending Physician:
 24 hours after death.
 Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 250No 1 Vi patient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending м 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2004 8006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIAN BOAi 31. Day (Month, Day, Year) MAR 2 6 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day MAJOR **Physician** DONALD W. 03 5:30 P.M 23 - 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08-18-1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 81 216-16-3809 Yrs. MARÝLAND Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🏋No MD. BALTIMORE TIMONIUM Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? GAILRIDGE ROAD 21093 306 U. S. A. or Items 23a by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after MXYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 WWII 1 ☐ Yes XX No Specify: Specify: WHITE 3℃Widowed 4 □ Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) Cotlege (1-4or 5+) SELF **EMPLOYED** GRAPHIC ARTIST 3 YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN Ε. MAJOR HILDA SCHLITSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (CAPANION) CAMILLA TRAHAN 306 GAILRIDGE ROAD, TIMONIUM, MARYLAND, 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If iter
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation XXIOther (Specify) ENTOMBM T DRUID RIDGE MAUSOLEUM 03-27-2004 PIKESVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD R. H. Kuth RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LIVER Cancer 426.5 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Hunknown Completed been Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Tes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After t or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after within 24 hours a To the Funeral C the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number March 23 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Baltanore mo 21214 Dum Charles 6601 ND N. Charles €32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 6 2004 Registrar

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			For State	State of Maryl		•	t of Health a e of Death	nd Mental	0.1	nnı.	001.50
	Physici		1. Decedent's Name (First, Middle, Las BETTY	η			OVITZ	2. Date of Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	wore		Town, or Location of			nty of Death	N/A
	Funeral Director		214-00-1044	x 7. Age (In	yrs. last birtho	Months		4 Hrs. 8. Date of	f Birth 3 3 , 1917	9. Birthr	place (State or Foreign MD
	Aaryland I show	or	Usual Residence of Decedent  10a. State 10b. County  MD N/		c. City, Town	or Location	RAI T	I MORE		1	0d. Inside City Limits 1 X Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show	<b>Funeral Director</b>	10e. Street and Number 2435 W. BELVEDER			10f. Zip			10g. Citizen	of What Coul	ntry? J.S.A.
9	172 hours after death with the Marylar "neturel", or Hems 23a or 28a-1 show edical Exertires assiste recilined at	Funera	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 M No If Yes, Give	in U.S.	13. Was Deced	ent of Hispanic Orig ify Cuban, Mexican,			Race - Americ Black, White,	
15-003	within 72 hours ane. than "neturel", he Medical Eve	Completed by	3 🕅 Widowed 4 □ Divorced  15. Decedent's Ed  (Specify only highest grad	Year or Dates: ucation de completed)	10	ecedent's Usua	I Occupation	of working		f Business/In	
d 212	Hygid Hygid Ither	Be Comp	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		1EMAKER		's Name (First, Mi	OWN I		
yland	should be ind Mental marked o	To B	SIMON  19a. Informant's Name/Relationship (7	ivos Printl		HWARTZ	(Street and Number	LLIE	umbar City or To		KAUFMAN
PSO.	and 2 sl ealth and n 27 le r		HOWARD MOFFET / S	ON	79!	58 STAR	BURST DRI	VE - BAL	ΓIMORE, N	1D 212	08
M0 ₹	Pages 1 nent of H int: if Iten		20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □  ↑ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery,	isposition (Nan crematory or o Z NUSAC	ther place)	Date 3/25/2004		on - City or To SEDALE	
Baltii	permit. I Departm Importer any injur		21. Signature of Funeral Sports Licen		ODAWITA	22. Name an	d Address of Facility	SOL LEV	INSON & E	BROS.,	INC.
	Physician		23a. Part1. Enter the disease, or some shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused the one cause on each line.	death. Do no	enter the mod	e of dying, such as c	ardiac or respirato	ory arrest,		Approximate Interval Between Onset and Death
11/4	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of)	Blood,	wfection	, , , , ,			20 days
8760,	icate be executed physician and sthe burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor  Due to (or as a cor  Due to (or as a cor							
Box 6	ath certiff attending for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 ☐Ectopic pr 5 ☐ Other (sp				Date of delive	ery Day Year
rds, P	quires that the de n signed by the uld be detached	d by P	Partl. Other significant conditions or dirabeter mellit	entributing to death but no	t resulting in t	ne underlying c	ause given in Part I.		Did tobacco use co		ne cause of death? ably 4 □Unknown
Division of Vital Records, P.O.	The faw requin cate has been si page 2 should i	Complete	Coronory antery	disease				8	utopsy performed?	b. Were auto prior to co death? 1  Yes	psy findings available inpletion of cause of
Vita	ysicien: s certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outp	atient 3 DC	Other	of Death (Check o	***	Other (Specif	v)
ion of	nding Ph ath. r: After th e funeral		27. Manger of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Tin Inju	ne of 2 iry M	8c. Injury at Work? 1 ☐ Yes 2 ☐ N	28d. Desci	ibe how injury occ		
Divis	To the Hospital or Attanding Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm oecify)	ı, street, factory	, office		on (Street and Nu Town, State)	mber or Rura	l Route Number,
	the Hospl hin 24 hou the Funer npletely fill	Medical		ysician: To the best of my liner: On the basis of examiner and manner stated.							
	To th withir To th	W	29b. Signature and title of certifier	tall MAN		290	Cicense number	6	29d. Date sig	ned (Month,	Day, Year)
	n		30. Name and address of person who	completed cause of death	(Item 23a) (T	/pe, Print)	7 (=5 00	V	March	241	2004
	Sta	ate	31. Date filed (Month, Day Year)		Signature .	tal of	Baltimor	٢			
	Registi		MAR 2 6	2004	in the	200					

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Austria

Race - American Indian, Black, White, etc.

SpecifyWhite

10d. inside City Limits

Approximate Interval Between Onset and Death

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No

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	9	permit. Pages 1 and 2 should be filed within 72 hours efter de Department of Health and Mentel Hydiene.
`	Baltimore, Maryland 21215-0036	ours
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3	7	permit. Peges 1 end 2 should be filed within Depertment of Health end Mentel Hydiene.
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	m	96

**Physician** 

/Medical

Examiner

**Funeral** Days 1 □ M 2 🔯 F Yrs 73 212-42-0220 Director Usual Residence of Decedent eth with the Meryland 10a. Stete 10b. County 10c. City, Town or Location Important: If tem 27 is merked other than "naturel", or flams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 000ce. Essex MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 114 Alcock Road 21221 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status ☐ Yes 2 ☐ No Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Westinghouse Elementary/Secondary (0-12) College (1-4or 5+) Electrical Worker 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) å Hilde Haberpointner Haberpointner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7935 InvernessRidgeRoad Potomac MD William Pitman /son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/04 BayviewCrematory Baltimore MD 22. Name and Address of Facility 21. Signature\_of Funeral Service Licensee ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or competications that caused the death profit enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Gram Negative Sepsis Examiner Due to (seas e consequence of) Physician/Medicai Examine ettending physicien end I for use es the bunel-transit requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) ed by the el deteched fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No Hypertension, Kenal been signed to should be det þ Completed 24a. Was an autopsy performed? s certificate has t director, page 2 s 1 Yes 2 KNo funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Certification: To 1 ☐ Yes 2DA No 1⊠Inpatient 2□ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 27. Menner of Death 5 Pending investigation 18 Natural 2 No death. 2 Accident efter death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò within 24 hours e To the Funeral C completely filled To the Hospital 29a. Certifier edicai (Check only 29c. License number 29b. Signature and title of Cartifile

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) MD D53462 pn who completed cause of death (Item 23a) (Type, Print) neses 9000 Franklin Sq. 30. Neme and address of per Baltimore, Md 21237 Square Drive Jude 31. Dete filed (Month, Day, Year) 32. Registrer's Signature MAR 2 6 2004 **ORIGINAL** 

State Registrar

		1 - For State Registrar	State of M	arylan		artmen rtificate			ınd M	Re	g. No. 20	04	09455
Physici		Decedent's Name (First, Middle,	Barba	ara F	ayne					2. Date of Death Month Mar	հ Դուր Մահանանանության համագրանության առաջանությունն առաջանությունն առաջանությունն առաջան առաջան առաջան առաջան ա	Year 4	3. Time of Death 10:00 p. <sub>M</sub>
/Medio Examir		4a. Facility Name (If not institution,	give street and number, Beaverbrook C			4b. City,	Town, or	Location o		umbia	4c. County of		ward
Funeral Director		5. Social Security Number 085-510-7486	5. Sex 1 □ M 2 F 7. A		last birthday) 90 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, February 9	Year) 9, 1914		lace (State or Foreign try) Wisconsin
p .		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	reation						1	0d. Inside City Limits
Maryla a-f ahov	ctor	Maryland	Howard	100.0	.,, 100010120		(	Columbi	а				1 □ Yes 200 No
38 or 28	i Dire	10e. Street and Number 4994 Beaverbrook I	Rd.			10f. Zip	Code	210	044	10	0g. Citizen of W	hat Coun U.S	
Interpretey, Interpretation Z.I.Z.13-0030 Int. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.  The strain of Health and Mental Hygiene is not an action of them 23a or 28a-f ahow ontant: if item 27 is marked other than "natural" or flems 23a or 28a-f ahow injury or other traumatic event, if a Medical Examinational be calling a injury or other traumatic event, if a Medical Examinational be calling a injury or other traumatic event.	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces  1  Yes 2  If Yes, Give Year or Dates:	Ever in U No			lent of Hi offy Cuba	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto i	ecity Yes or No- Rican, etc.)		- Americ , White,	an Indian, etc. White
ithin 72 hours nen "neture	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education		16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	rk done d se retired	furing most	of worki	ng	16b. Kind of Bus		dustry cation
lal y allo Z I Z 2 should be filed with and Mental Hygiene, is marked other than aumatic event, the	Be	17. Father's Name (First, Middle, L Ja							r's Name	(First, Middle, M	Maiden Sumame Ella Serrell	s)	
and 2 should all yes saith and Mer n 27 is marke	To	19a. Informant's Name/Relationsh Ms. Virginia Pari		hter						al Route Number, Dia, Marylan		state, Zip	Code)
Daltimore, IVI permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition  1 □ Burial 2 Cremation  4 □ Donation 5 □ Other (Sp		, (	Place of Disponentery, cres	natory or o	ther place		3-2	Date :	20c. Location - ( Syke		wn, State Maryland
Definit. Pages Department of Important: If is any injury or ones.		21. Signature of Funeral Service U		10120	92	2. Name an	d Addres Slack F 3871 C	s of Facility Funeral Old Colu	Home		City, MD 2	1043	
Physician /Medical Examiner	_	23a. Part1. Elder the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Dub to (orla	) (ARC) s a consec M m/	quence of):	In ery	Arct Dist	g, such as	cardiac o	or respiratory arre	est,	t	Approximate Interval Between Onset and Death
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or a										
the death certifica the attending phythe attending phiched for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ≧ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3	∃Ectopic pr ∃ Other (sp					23d. Date Mon		ery Day Year
requires that the seen signed by the hould be detached.	by	Part If. Other significant condition	ns contributing to death	but not res	sulting in the u	nderlying c	ause give	en in Part I.				bute to th	ne cause of death?
10 E S C	Completed								_	24a. Was an autops perform	y pr ned? de	ere auto ior to cor eath? Yes	psy findings available inpletion of cause of
OT VICAL Physician: This certifical ral director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpat		ER/Outpatier			9r: 4 ☐ Nu	rsing Ho	me 5 Reside	ince 6 othe		ASSISTED IN
VISION OF Attending Physical death. Sector: After this by the funeral di	ation:	27. Manner of Death Natural 5 Pending 2 Accident investig	ation	ay Year)	28b. Time o fnjury	M	8c. Injury Work	/ aτ ⟨? Yes 2 □ l		28d. Describe ho	w injury occurre	a 	
To the Hospitel or Atlending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place of it building, e	tc. (Speci	ify)					28f. Location (Sti City or Town	, State)		
he Hosp in 24 hou he Funei pletely fil	edical	29a. Certifier 1 Certifying (Check only one) Medical E	g Physician: To the bes Examiner: On the basis and manners	of examina	owledge, deat ation and/or in	h occurred ivestigation	at the tim , in my op	ne, date an pinion, dea	d place, a	ed at the time, da	ate and place, a	nd due to	the cause(s)
To t To t	Σ	29b. Signature and title of certifier	Zun			290	theense	1786			9d. Date signed $7-19-$		Day, Year)
3		30. Name and address of person Katz, Jeffrey 4994	who completed cause of Beaverbrook Rd.	death (Ite , Colun	m 23a) (Type, nbia, MD	Print) Colum	bia, M	D 2104	5				
St. Regist	ate	31. Date filed (Month, Day, Year)	32. Regis	trar' Sign	ature	6	and a	<u>}</u> -					

State of Maryland / Department of Health and Mental Hygiene 2 For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** Russell Payne Rose MARCH 25. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 22, 1910 Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2□ F 93 Virginia Director 217-01-8942 Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 U.S.A. or Items 23a 125 Beniies Road Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: 3 XX Vidowed 4 ☐ Divorced White "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Aero-Space i. Pages 1 and 2 should be filed witness of Health and Mental Hygier tant: If Item 27 is marked other theury or other treumatic event, In 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Edward Rose Lodie Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4108 Beachwood Road, Baltimore, Maryland 21222 George D. Rose (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State opartment or Important: If Its any injure 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State 03/28/2004 Baltimore, Maryland Gardens Of Faith 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DDC Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part y Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician BLADDER CANCER /Medical Due to (or as a consequence of). **Examiner** METABOLIC ACIDOSIS SECONDARY RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exan iner The law requires that the death certificate be executed AND SEPSIS and Due to (or as a consequence of): the burialphysicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown ģ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed res 21 2 No 1 Tes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 this the funeral 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Tella 2011 D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature P DRIVE TOWSON, MARYLAND 21204 JOGINDER MEHTA, OSL M. 31. Date filed (Month, Day, Year) State MAR 2 6 2004

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 23 Eugene Royston Sr. March 2004 6:30 Kenneth /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Caroline 202 School Street Greensboro 8. Date of Birth (Month, Day, Year) Nov 17, 1931 If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 216-28-2465 72 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits itsm 27 is marked other then "neturel", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2/1/No Caroline Greensboro Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 School Street 21639 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John W. Royston Maud Haynes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If itsm 27 ie eny injury or other trau once. Mrs. Mary Royston / Wife 202 School Street Greensboro, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March Date 6 1X Bunal 2 Cremation 3 Removal from State Glen Haven Memorial Park Glen Burnie, MD 2004 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, 21. Signature of Funeral Service Licensee 1 Second Avenue, S.W. Glen Burnie, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 2/3 NO 1 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has autopsy performed 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2NNo 5 Residence 6 □Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After the Hospital or Attending in 24 hours after death. 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral L 15/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) De Registrar's Signature Bar 2004 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 24,2004 E. Rembis **Physician** Agnes 3:15 P.<sup>™</sup> /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore City St. Joseph Manor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 24,1924 1 ☐ M 2 ☐ F October 79 217-22-4444 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Exeminar must be notified at N/A Baltimore City Maryland 1 X Yes 2 □ No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21210 U.S.A. 911 W. Lake Avenue death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
nent of Health and Mental Hygiene.
nent if item 27 is marked other than "natural; or fleauralto event, the Mendical Equilities my or other (faurnatic event, the Mendical Equilities 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yr's Secretary Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rembis Cecilia Christopher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Edward Mullowney - Friend 911 W. Lake Avenue Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary March 26,2004 Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21214 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
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9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. as been signed 2 should be de 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed certificate 1 Yes 22 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 1 Yes 2 2 ER/Outpatient 3 DOA 4₽ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 27. Manner of Lath 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide hours after within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 6 2004 Registrar

Physician		Decedent's Name (First, Middle, I	Last		partment of leartificate of		2. Date of Dea Month	ith Day	Year	3. Time of Deat
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a-f show		Maryland 10b. County	Baltimore	10c. City, Town or	Location	Irvington				1 🗆 Yes 2
3a or 28a-f elities notified		10e. Street and Number 3441 Old Frederick I	Rd.		10f. Zip Code	21223		10g. Citizen o	of What Cour U.S	
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P.0	that the de ed by the delached	F.	9 X Unknown Part II. Other significant conditions co	entebuting to death by	it not resulting	n in the u	nderlying (	cause dive	an in Part I		23e. Did 1	lobacco u	ise contribute to	the cause of death?
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of	Physer this eral di		27. Manner of Death	£8a Date of Injur	v (28)	nidne o		28c. Injury	at		28d. Describe		-A-	SCENE
ion	nding ath. r: Afte	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	3/23/10 23	11:	:30 <sup>11</sup>	a <sub>M</sub>	Work	ves <b>≵√x</b> !	No S	subject i	ingest	ed ethyle	ne glycol
Division	er deer rector	Certification:	3. Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju-		farm, str	reet, factor	y, office						iral Route Number,
Ö	Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certific tely filled in by the funeral director.			residence			-							ite Hall, MD
		Medical		sician: To the best of iner: On the basis of and manner sta	examination.									
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29	c. License	number			29d. Dat	e signed (Monti	h, Day, Year)
) ,	-		hy his	MiP				O.C	.M.E.		ľ	MARCH	1 24,200	04
J.			30. Name and address of person who o	_	eath (Item 23a									
<	1				de Cinnet		114 F	enn	Stree	et, B	altimo	re, M	Maryland	1 21201
	Sta Regist		31. Date filed (Month, Day Year) MAR 2 6 2004	late filed (Month, Day, Year)  MAR 2 6 2004  Registrates Signature)  MAR 2 6 2004										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1102 A SALVANT ODESSA march 19 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** RANDALLSTOWN HOSPITAL NORTHWEST BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 K CHICAGO. Director 86 DEC 3, 1917 11 294-18-6718 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28e-f show f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-1 show other treumstic event. Ite Mouthal Expiriting that the restitled at 1 ☐ Yes 2 No PIKESVILLE Directo MARYLAND BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21208 940 MILFORD MILL ROAD Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3√√ Widowed 4 □ Divorced BL ACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETAIL FLORIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be COKER CHRISTOPHER **CLARA** NATHAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 940 MILFORD MILL ROAD, PIKESVILLE, MD 21208 CAROLYN BRADFORD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportent: if ite any injury or of once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Memoval from State
4 ☐ Donation 5 ☐ Other (Specify) 3/22/04 Markeld HTS WHITEHAVEN MEM. PARK 21. Signature of Funeral Service License 22. Name and Address of Facility FINK FUNERAL HOME, P.A. KEILYCORECOK 426 CRAIN HIGHWAY S., GLEN BURNIE, MARYLAND 21061 FTNK #MO17 I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Asp, ration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a confequence of): use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed عسروتن Due to (or as a consa uence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ó Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 3 No 1 Yes 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1. Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Murch D 0059736 MID Duntson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROND 21137 DEBURAH m.o 5401 040 court RANDALITOWN WA7 55N 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 6 2004 Registrar

			Please I	State of Maryland /			-	_	
		•	For Stete Registrar	State of Maryland /	Certificate of I		Reg. No	201	09462
			Decedent's Name (First, Middle, Last)	0			2. Date of Death		3. Time of Death
	Physici /Medic		ROBERT DANA	STERLIN			MAKCH 2	4,2004	12,10p, M
	Examin	er	4a. Facility Name (If not institution, give s なれてけれれでは Racit AVIII)	treet and number) TATION EXTENDE		r Location of Death BALT	- WIAD-	County of Death	•
900	Funeral		5, Social Security Number 6. Sex	7. Age (In yrs. last b	irthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year)		place (State or Foreign
	Director	-	Usual Residence of Decedent	W 201	Yrs.		July 24, 19	140 11/U	ryjana
	show	ō	10a. State 10b. County		wn or Location timore				10d. Inside City Limits
	or 28e-	Director	10e. Street and Number	1 0.12	10f. Zip Code	2	10g. Cit	izen of What Cou	ntry?
	s 23a	erai [	2954 Greenmou	2. Was Decedent Ever in U.S.	13 Was Decedent of H	Spanic Origin? (Spec	ify Yes or No-	14. Race - Ameri	can Indian.
920	ges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28e-f show or other traumatic avent, the Medical Examble matter and the notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Provorced	Amed Forces?  1 Pyes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	lican, etc.)	Black, While,	
15-0	"natur	Completed	15. Decedent's Educ (Specify only highest grade		a. Decedent's Usual Occup (Give kind of work done of fife. DO NOT use retired	during most of workin		ind of Business/Ir	dustry
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Maryland 21215-0036	should be filed nd Mental Hygi marked other umatic avent, II	To Be C	Charles D. Ste	erling	9	Virgini	(First, Middle, Maiden	?S	
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	es 1 and of Health fitem 27 r other tr	l	20a. Method of Disposition 1 ☐ Burial 2 Ø gremation 3 ☐ R	comet	of Disposition (Name of ery, crematory or other place			ocation - City or T	own, State
Baltimore,	Pa ant ury		* 4 □ Donation S □ Other (Specify)	metro	Crematory	5-26	-04 (Cato	insuille,	MD
Ball	permit. Pag Department Importent: any injury o		21. Signature of Feneral Service Licens		22. Name and Addre	SS OF Facility	Enadhiltar	Agg Ba	11229 110.1MD
	To g		23a. Part / Enter the disease, or complication shock, or near failure. List only on	cations that caused the death. Do	not enter the mode of dyin	ng, such as cardiac or	respiratory arrest,	1683 100	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CHOLANGI	OCARCINO	MA		-	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):			1	
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of			27. Manner of Death		Outpatient 3 DOA  Time of 28c. Injury Wor	y at 2	8d. Describe how injur		9)
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1	Hospitel 24 hours a Funeral letely filled	Medical	29a. Certifier (Check only one) Certifying Physical Exemination (Check only one)	ician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at the tin and/or investigation, in my o	ne, date and place, a printon, death occurre	nd due to the cause(s) d at the time, date and	and manner as a place, and due t	stated. o the cause(s)
	To the within 2. To the Complete	Me	29b. Sign, ture and title of certifier	T 1. a	29c. Licens	e number	29d. Da	te signed (Month,	Day, Year)
)	1		Munda C,	mpleted cause of death (Item 23a	(Type Print)	14958	MAR	CH 24	, 2004
			AURORA C. TAN	3900 LOCH	PAVEN BOU	ILE VARD	BALTIMO	RE, MI	21218
	Sta		31. Date filed (Month, Day, Year)		Soule			•	

		1 10430 1	State of Maryland		ent of Health and	•	riene	
		1 - For State Registrar	State of Maryland		ate of Death		300 No. 200	+ 09463
		Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
Physici /Medi		Rosalie Si	adowski			Month 3	2/ 2004	
Examir		4a. Facility Name (If not institution, give :		D	ty, Town, or Location of Dee	th ·	4c. County of Dea	
		Johns Hapking Bay U/c 5. Social Security Number 6. Sec			der 1 Year I If Under 24 Hrs	8. Date of Birt	N /	A thplece (State or Foreign ountry)
Funeral Director			M 20%F 77	Yrs. Month	ns Days Hours Min	8. Date of Birt (Month, Day 12/18	8/26 MAR	OUNTRY) YLAND
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1 the N	rect	MD N/A		BALTIMOR 101.	. <u>다</u> Zip Code		10g. Citizen of What C	ountry?
death with the Maryland ma 23a or 28a-f ehow roust be notified at	Funeral Director	310 S. WOLFE	STREET		21231		USA	
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ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	use retired)			
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Department of the post of the		Fugue !	low A		DUNDALK AV			ID. 21222
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DIVISION  To the Hospital or Attency within 24 hours after death  To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 - Certifying Physical Check only 2 Medical Examination one)	sician: To the best of my know ner: On the basis of examination and manner stated.	on and/or investigati	on, in my opinion, death occ	urred at the time, o	date and place, and du-	e to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	2	:	29c. License number	2	29d. Date signed (Mon	th. Day, Year)
		Mills Tell	ent		Bay view C		3 - 0	22-2004
2		30. Name and address of person who co	impleted cause of death (Item:	23a) (Type, Print)	0 - 0	D	11-	010 2 /2 2 //
Sta	ite	31. Date filed (Month, Day, Year)	32. Agistrar's Signati	Hup Kins	BAJUIEW C.	rcle B	withmare,	LI LI CLY
Regist		MAR 2 6 201	14 Dem 1	A Sport	0			

UNK 04-086 04-02001 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RKD State of Maryland / Department of Health and Mental Hygiene QURAN R. TATE 1 - For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death Month 1. Decedent's Neme (First, Middle, Last) **Physician** MARCH 21-2004 9:51A. uran /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES 5427 16th AVENUE APT.104 CHILLIUM | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Director unk Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ed other than "netural", or itams 23e or 28a-f show event, the Medical Examenational by confided at N☐Yes 2☐No Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Apt. 42 venue by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 end 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "netural", or Itar ☐Yes 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be rona 19a. Informant's Name/Relationship (Type, Print) Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) > tatima 25019 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite 1 ☐ Burial 2 ★Cremation 3 ★Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mem. 2004 amella Lawn 22. Name and Address of Facility

JOSEPH L. RUS 21. Signature of Funeral Service Licenses WiNorth 23a. Part /Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Examiner Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi the attending physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death lor in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe þ 3 Probably 2 X No 4 Dunknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 Mayes 2 □ No 24a. Was an 1 Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify SCENE 1 Yes 2 □ No 3□ DOA 2 2 ☐ ER/Outpatient this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural Injury 5 Pending Shot 9:10 AM 1 ☐ Yes 2 No Subject 2004 death. investigation 3/21 thours after death. 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 16th Ave within 24 hours a To the Funeral I the Hospital 29a. Certifier t 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MARCH 22,2004 O.C.M.E.

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of

MAR 2 6 2004

Series

& Sparker

Maryland 21201

			For State Registrar	State of N	Maryland		artment o			Mental Hy	giene Reg. No 2	104	09465
	Physici	1. Decedent's Name (First, Middle, Last)  Thelma Marie Thornbloom  dical niner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death									Day arch 22, 20	Year 004	3. Time of Death 8 p.m. M
	/Medio Examin					nter	4b. City, Tov	vn, or Lo		th licott City	4c. Count	y of Death	ward
	Funeral Director		475.01.7040	6. Sex 1 M 2 F	Age (In yrs. la 86		If Under 1 Y Months D		Under 24 Hrs lours Min		ay, Year)		olace (State or Foreign htry) Minnesota
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland	Howard	10c. City,	, Town or Lo	cation	Ellic	ott City			1	0d. Inside City Limits 1 ☐ Yes 2 No
	a with the	I Director	10e. Street and Number 3032 Oak Grove Cir	cle			10f. Zip Co	de	21043		10g. Citizen of	What Coul	*
980	within 72 hours after death with the Maryland ane. than "ratural, or items 23a or 28a-f show ta Marical Examinar mast be natified at	by Funeral	11. Marijal Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force ad 1 Tyes 2 If Yes, Give Year or Date	s) No		Was Decedent f Yes, specify		nic Origin? ( Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	14. Ra Bta Speci	ce - Americack, White,	
21215-0036		Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4c	or 5+)	(Give	dent's Usual O kind of work o DO NOT use n Fe	lone durir etired)	n ng most of wo Employee	_	16b. Kind of 8	Business/In U.S.	,
Maryland 2	be od o	17. Father's Name (First, Middle, Last) Swan Alys Thornbloom								me (First, Middle Nel	, Maiden Suma lie Glagys		
	nd 2 sho lith and 27 is m r traum		19a. Informant's Name/Relationship (Type, Print)  Ms. Darlene McLennon Sister  19b. Mailing Address (Street and Number or Rural Route 2068 West Skillman St. Paul, Min									, State, Zip	Code)
Baltimore,	Pages 1 and nent of Healt int: If Item 2 iry or other		20a. Method of Disposition  1 Burial 2 □ Cremation  2 □ Donation 5 □ Other (Sp		l ca	metery, crer	sition (Name of matory or other twood Cet	r place)	,   0	Date 3/27/2004	20c. Location	_	own, State ntre, MN
Balti	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service	C nsee	00120	3 22	Name and A Slat 387	ck Fun	eral Hon	ne, P.A. a Pike Ellico	tt City, MD	21043	
	Pnysician / Medical Examiner portion and program and program program fransit	Examiner	23a. Part1. Enter the disease) or shock, or near failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	ı line.	ence of):	er the mode of	N		ic or respiratory a			Approximate Interval Between Onset and Death
P.O. Box 68760,	death certificate e attending phy: od for use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 22☐ No 9 ☐ Unknown	d	ne of pregnan 2 □ Fetal at time of de	ncy death 3 ath 5	Ectopic pregn	ý)			М	ate of delive	Day Year
Records, I	The law requires that the ate has been signed by th page 2 should be detache	<u>م</u>	Part II. Other significant condition  HUPUTHER	OIDISM	but not resul	lting in the ui	nderlying caus	e given ir	Part I.	239. Did 1	Yes 2□No	3 🗌 Prob	ably 4 Qunknown
al Rec		e Completed	25. Was case referred to medical					26	Diago of Do	auto	osy ormed? 2D No	prior to condeath?	psy infollings available inpletion of cause of
of Vital	Physician: r this certific ral director,	ToB	examiner? 1  Yes 2 No	Hospital:		ER/Outpatien 28b. Time of		Other		Home 5 ☐ Resi			y)
Division (	al or Attending F after death. I Director: After d in by the funer	Certification:	27. Manner of Death   Natural 5   Pending investig   3   Suicide 6   Could n   4   Homicide   determine	ot be 28e. Place of	Day Year)	Injury ne, farm, str	М		2 □ No		Street and Num		l Route Number,
Ö	- 9		29a. Certifier 1 Certifying	Physician: To the be	st of my know	vledge, death				e, and due to the	cause(s) and m		
	To the Hospital o within 24 hours at To the Funeral D completely filled in	Medical	(Check only 2 Medical E	xaminer: On the basis and manner		on and/or in		my opinio		urred at the time,	date and place, 29d. Date signs		
	8 4 € 4		Lasueu	n Lale	luan	~`	-	)20	35-91	-	3/2	3/00	1
_	10		30. Name and address of person v	CAKHAN	1, 7.	220	Print) PAK	K	1/210	ntist	IVE, K	BACI	DM1)24208
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 2 6 2004  MAR 2 6 2004										

**Physician** 

/Medical

**Examiner** 

Director

Completed by Funeral

Be 10

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Importent: If item 27 is marked other then "neturel" or Items 23a or 28a-1 show any injury or other treumatic event, The Medical Exarchited at once.

Pnysician /Medical

Please	Type or Print in				-		gible.	
_ For	State of Maryla	nd / Depa	rtment of H	ealth and	Mental Hy	giene		
State Registrer		Cen	tificate of	Death		Reg. No. 2	004	09466
1. Decedent's Name (First, Middle, L	ast)				2. Date of De.	ath Day	Year	3. Time of Death
Valerie J.	Wilcon				March	24	2004	1146 A M
4a. Facility Name (If not institution, g			4b. City, Town, o	Location of De		4c. Co	unty of Death	
Sinai Hospil	ral of Bal	timore	Baltim	one Ci	1+			
5. Social Security Number 6.	Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 H		h y, Year)	9. Birth Cou	place (State or Foreign
218-58-9178	1□M 2XF 52	Yrs.			03/05/		1	land
Usual Residence of Decedent  10a. State 10b. County	100 0	ity, Town or Loc	ation					10d. Inside City Limits
Toa. State Tob. County	100.0	Baltimo						1 TYes 2 □ No
Maryland		Dartimo						
10e. Street and Number			10f. Zip Code			•	of What Cou	intry?
2503 Violet Av			2121			U.S.		I. di
11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14.	Race - Amer Black, White	
1 Never Married 2 Married	If Yes, Give	1	☐ Yes 2☐XNo	Specify:		Sp	ecify: B	lack
3 Widowed 4 Divorced	Year or Dates:	160 Doords	ent's Usual Occup	ation		16h Kind	of Business/I	nduetny
15. Decedent's (Specify only highest)	grade completed)	(Give k	rind of work done	during most of w	vorking	TOD. KING	JI 003111633/1	industry
Elementary/Secondary (0-12)	College (1-4or 5+)			,		Homen	aker	
10 17. Father's Name (First, Middle, La	st)	пос	sewife	18. Mother's N	ame (First, Middle,	Maiden Su	mame)	
Andrew Leak	,			Grace	Henry			
19a. Informant's Name/Relationship	(Tune Print)	19h Mailing	Address /Street			or. City or To	wn State Z	ip Code) 21133
Delores Robinson	•							m, Marylan
20a. Method of Disposition		Place of Dispos	ition (Name of		Date		on · City or 1	
1 ☐ Mourial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	cemetery, crem	atory or other place em. Pk.	in3/	30/2004		•	Maryland
21. Signature of Funeral Same L	599	22.	Name and Addre	ss of FacilityTh	e Derricl			7/H, P.A. 7land 21215
23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused the dealy one cause of each line.						, 1141)	Approximate Interval Between
Immediate Cause (Final disease or condition	Sensis							Onset and Death
resulting in death)	Due to (or s a conse	quence of):						1
	b							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unseaso or injury)	Due to (or as a conse	quence of):						
Cause (Disease or injury that initiated events	C						- 1	
resulting in death) Last	Due to (or as a conse	quence of):						
	d							
IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 🔲	Ectopic pregnancy Other (specify)			23d	Date of delin Month	very Day Year
Part II. Other significant conditions	s contributing to death but not re	sulting in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
Hypertension	-1 )	AIDS	(En) S	itage)	1821	_		bably 4 ∐Unknown
/				0	24a. Was autop perfo 1  Yes	rmed?	4b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of

**Examiner** Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical þ Be Completed Medical Certification: To

Hypertension	Stroke,	A1105 (En	d Stage)	1 Ves 2	No 3 Probably 4 Unknown
			3	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Mo
25. Was case referred to medical			26. Place of Dea	ith (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2 E	ER/Outpatient 3 DOA	Other: 4 Nursing H	ome 5 Residence 6	Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	(Month, Day Year) on	28b. Time of 28 Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	roccurred
3 Suicide 6 Could not determine		me, farm, street, factory,	office	28f. Location (Street and City or Town, State)	f Number or Rural Route Number,
	Physician: To the best of my know aminer: On the basis of examinati and manner stated.				
29b. Signature and title of certifier	•	29c.	License number	29d. Date	e signed (Month, Day, Year)

RES-000

Murch

24

2004

2 State Registrar

Sinai Hospital
32. Registrar's Signature 31. Date filed (Month, Day, Year) MD MAR 2 6 2004

29 30. ame and address of person who ombleted cause of death (Item 23a) (Type, Print)

MD

			1 - For State Registrar	State of Mar		artmen rtificat			ind M		Reg. No.	200	. 0	946	57
	Physici /Medio		1. Decedent's Name (First, Middle, Las Bernice Wajer	:t)						2. Date of De Month March	Day 23,	/ Year 2004		me of Death	
	Examin		4a. Facility Name (If not institution, give Heritage Nursing				Town, or unda	Location o	f Oeath		4c.	County of De Baltir			
	Funeral Director		217 30 3007	9x 7. Age (I ☐ M 25☐ F 89	In yrs. last birthday) Yrs.	If Under Months	1 Year Oays	If Under a	Min.	8. Date of Bir (Month, Da Feb. 15	th ly, Year) , 19	9. B 15 <b>M</b> á	irthplace (S Country) arylar	itate or Fore	ign
	aryland show dat	_	Usual Residence of Decedent  10a. State 10b. County		0c. City, Town or Lo							<u></u>		ide City Lim	
	h the Mi	Funeral Directo	Maryland Baltimo	ore	Esse	X 10f. Zip	Code				10g. Citi	izen of What (		1169 27	-
	ath wit	raiD	506 Delaware Aver				1221					JSA			
980	ours after deg el', or items	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Deced If Yes, spec 1 ☐ Yes		spanic Orion, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)	-	Black, Wh	lace - American Indian, clack, White, etc. city: White			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Estiminar must be notified at anone.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	of workii	ng		ind of Busines	-							
70	should be filed and Mental Hyg s marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) William Russell	(First, Middle, e Kendr		Sumame)									
Man	12 sho h and I 7 Is ma trauma		19a. Informant's Name/Relationship (7	Route Numbe											
Baltimore, I	Pages 1 and ent of Healt ht: If Item 2 ry or other		Jeannette Wajer (  20a. Method of Disposition  1  Burial 2  Cremation 3    4  Donation 5  Other (Specify	ltimore ate 6/2004	20c. Lo	cation - City o	r Town, Sta								
Batti	permit. I Departm Importar any inju		21. Signature of Funeral Service Licen	1 Home venue I	P.A.										
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complete shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	blications that caused the one cause on each line.  a. Due to (or as a control of the control of	ARDI	A L RT	e of dying	, such as VFA	cardiac o	TION SEA	rrest, J SE		Interva	ximate al Between and Death	) . 25
8760,	Attending Physician: The law requires that the death certificate be executed refeath. cardet his certificate has been signed by the attending physician and sector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	lical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ESSEN Oue to (or as a c	CTIAL	H	1 PE	ERT	EN	1510	2		25	YEA	RS
.O. Box 6	it the death certifics by the attending ph tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 moeths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of a 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	☐Fetal death 3 ☐	Ectopic pr					23d. Date of delivery Month Da			Year	
α.	quires that n signed b uld be deta	þ	Part II. Other significant conditions of	DEMEN	not resulting in the u	nderlying c	ause give	n in Part I.			obacco u /es 2 (	se contribute ⊒No 3 □ F		e of death?	wn
Il Records,	The law requir cate has been sl page 2 should I	24a. W										24b. Were a prior to death?	completion	n of cause o	ole
Zita Zita	yslcian: The l is certificate he director, page	25. Was case referred to medical examiner?										COthor (Co	20161)		
Division of Vital	utending Phys death. ctor: After this y the funeral di		1 Inpatient 2 Levolupatient 3 DOA 4 Nursing Home 5									ne 5 Residence 6 Other (Specify)  8d. Describe how injury occurred			
Divis	in Life	Certification:										8f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medicel Exem	ysicien: To the best of n niner: On the basis of ex and manner stated	amination and/or in	vestigation	in my op	inion, deat	d place, a h occurre	d at the time,	date and	place, and du	e to the ca		
1	To the within To the comple	2	29b. Signature and title of certifier	mgh M	D	290	License	1416	00	M	ARC	e signed (Mor	20	04.	
	3		30. Name and address of person who	completed days had deal	Signature	Prigr) 7-	AAF	RIT	ANE	IE H	19H	25·	, ISA	LTIMO	RE
	Sta Registr			Date filed (Month, Day, Year)  MAR 2. 6 2004  32 degistrar's Signature											

		1 - For State Registrar		laryland / De	partment of I ertificate of		· · · · · · · · · · · · · · · · · · ·	Reg. No. 200		
/Me	sician edical	PUVLI	Ab City Town	or Location of	2. Date of Do Month	Day The Year 25 200	04 3.00 AM			
Fune Direct	_	HARBORSIDE NURSING HOME  5. Social Security Number  1 M 2 F  Yrs.			If Under 1 Year	BALTIMORE N/A  If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign				
Q		Usual Residence of Decedent 10a. State 10b. Cou		10c. City, Town or BA	Location LTIMORE		<u> </u>		10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
be filed within 72 hours after death with the Maryland half Hygiene. Ital Hygiene. Indicate them "natural", or items 23a or 28s-f show event, the Medical Examinat must be retiriled at	Funeral Director	10e. Street and Number  2401 LOUISE  11. Marital Status	2401 LOUISE AVE  11. Marital Status  12. Was Decedent Ever Armed Forces?		10f. Zip Code  21214  n U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen		n? (Specify Yes or N Puerto Rican, etc.)	10g. Citizen of What Country?  USA  city Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.		
in 72 hours after n "natural", or head examined	Completed by F	3 ☐ Widowed 4 ☐ Divor	2. Widowed 4 □ Divorced If Yes, Give X Year or Dates:  15. Decedent's Education (Specify only highest grade completed)		1 ☐ Yes 2√2 No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			Specify: BLACK  16b. Kind of Business/Industry		
	Re Comr	17. Father's Name (First, Midd	12 17. Father's Name (First, Middle, Last)			OUSEWIFE  18. Mother's Name (First, Middle, M				
III.III.OI.E, IVIGITYIGII nit. Pages 1 and 2 should be artment of Health and Menta artment: If item 27 Is merked iniury or other traumatic e	, L	19a. Informant's Name/Relati	ROBERT HENDERSON  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  JAMES WHITAKER, SON  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State)							
Dattillor permit. Pages Department of I Important: If ite		'		e cemetery, o	rematory or other pla	PK 0	3-30-04	MARYLANI	)	
by Science of Physician and Ph	an al er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
The Colids, T.C. BOX 00/00  The law requires that the death certificate be eath has been signed by the attending physician page 2 should be detached for use as the burity	100			2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of d Month	elivery Day Year	
w requires that been signed be detailed.	efed by Pl	Part II. Other significent conditions contributing to death but not resulting in the			e underlying cause gr	1   Ye			obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Dinknown	
The lay ate has	2	24a. Was an autopsy findings available prior to completion of cause of death?  25. Was case referred to medical examiner?						completion of cause of		
ng Phy dier this	F	1 Yes 2 No	28a. Date of In (Month, D estigation	I   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Oursing Home   5   Residence   6   Other (Specify)						
Z Z D D	al Certification.	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, far building, etc. (Specify)			City or Town, State)  ath occurred at the time, date and place, and due to the cause(s) and n			wn, State)		
To the Hospital or within 24 hours after To the Funeral Director Completely filled in	Modical	(Check only one)  2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifler  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature						ue to the cause(s)		
3		30. Name and address of per	son who completed cause of	death (Item 23a) (Ty	pe, Print)	mid	e, red	-2123	39.	
Reg	State istrar	MAR	2 6 2004	NEWS &	Soule					

**ORIGINAL** 

			1 - For State Registrar		partment of Health ar ertificate of Death	Reg. I	No. 2004 09469
	Physic /Medi			y Eileen Womack		March.	Day Year 2004 4:20 pm
	Examir Funeral Director	ner	339-10-3419	al Hospital	Months Days Hours	1 itu	N/A  9. Birthplace (State or Foreign Country)  Illinois
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-f ehow may injury or other traumatic event, the Medical Examinational Decision on the providitied at an angle.	ed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland Prince Ge  10e. Street and Number  5813 Ottawa Stree  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S.  Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	Heights  10f. Zip Code  20745  3. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	(Specify Yes or No- Guerto Rican, etc.)	10d. Inside City Limits 1 □ Yes 2 No  Citizen of What Country?  SA  14. Race - American Indian, Black, White, etc.  Specify: White
Baltimore, Maryland 21215-0036	be filed within 72 ntal Hygiene. of other than "ne	Be Completed	(Specify only highest grad Elementary/Secondary (0·12)  17. Father's Name (First, Middle, Last)	completed) (Gi College (1-4or 5+) 1 Sta	ve kind of work done during most of 5. DO NOT use retired) LISTICIAN  18. Mother's	r working Fe Name (First, Middle, Maid	deral Government
Maryla	alth and Mer 27 is marke r traumatic	To	Gregorio N. Perez- 19a. Informant's Name/Relationship (Ty Gregory Womack/Son	rpe, Print) 19b. Ma	leres  Address (Street and Number of Ottawa St. Fore		
timore,	t. Pages 1 a timent of Heg tent: If Item		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 6 ☐ Other (Specify)	lemoval from State Ft. Lin	position (Name of rematory or other place) coln Cemetery 3/	24/04 Bre	Location - City or Town, State
Baj	permit Depar Impor eny in		21. Signature Tuneral Service Licens	N/ I	22. Name and Address of Facility 6160 Oxon Hill R	d. Oxon Hill	, Md. 20745
8760	cate be executed //Medical bhysicien and physicien and the burial-transit	Ilcai Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Gao or rospiratory arrost,	Approximate Interval Between Onset and Death
.O. Box 6	death certifi e attending d for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B Ectopic pregnancy Country Other (specify)		23d. Date of delivery Month Day Year
S, D	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant conditions cor	tributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?
tal Reco	in: The law r ilicate has be or, page 2 shi	e Completed	25. Was case referred to medical			24a. Was an autopsy performed? 1 Yes 2 A	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Division of Vital Record	To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director After this cerulicate has completely filled in by the funeral director, page 2	To B	evaminer? 1	ospital: 1 Inpatient 2 ER/Outpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) Injury	ent 3 DOA Other: 4 Nursing Nursing Nursing	Death (Check only one)  Ing Home 5 Residence  28d. Describe how inj	
Divis	pitel or Atte burs after de erel Directo	l Certification;	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, Sta	
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	(Check only one)  2 Medical Examination (Check only one)	sician: To the best of my knowledge, dea ner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death o	occurred at the time, date ar	nd place, and due to the cause(s)
)			30. Name and a stess of person who co	moleted cause of death (from 32a) (Turn	29c. License number		ate signed (Month, Day, Year)
)	Sta	te	31. Date filed (Month, Day, Year)	32/Registrar's Signature	iryland Gene	ral Hospi	tal
	Registr		MAR 2 6 200	4 Brow & A	and :	*	

		For State Registrar  1. Decedent's Name (First, Middle, Last,	State of M	larylan				ealth a Death		R Date of Dea	eg. No.	200	3. Time	947
Physic /Medi		John Harold A	bell, J			45 00	T		Dooth	March	1	200	4 2:3	80 P M
Exami	ner	4a. Facility Name (If not institution, give Anne Arundel Medi				-	Annap	Location of	Death			ne Arı		
Funeral Director					last birthday) Yrs.		r 1 Year	If Under 2 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day 09-05-	1	9. Bi	nthplace (State country) shingto	
and		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits
Maryli -f sho	to	Maryland Anne Aru	ndel		Har	wood							1 🗆 Y	es 2X No
th the or 28a	Oirec	10e. Street and Number				10f. Z	p Code			1		en of What C	ountry?	
s 23a	ra	4462 Owensville S	12. Was Deceder		C 13	Was Dan	207		in? (Specif	by Ves or No-		USA A Bace - Am	encan Indian	
72 hours after death with the Maryland natural, or Items 23a or 28a-f show dical Exemples must be notified at	by Funeral Director	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	Armed Forces  1 Yes 2 Note of the control of the co	5? ] No		If Yes, sp		Specify:	Puerto Rio	fy Yes or No- can, etc.)		Black, Wh		'
	Completed	15. Decedent's Edu (Specify only highest grad		r 5+)	16a. Dece (Give life.	kind of w		durina most	of working		16b. Kind	d of Busines	s/Industry	
e filed within al Hygiene. other than '		17 February Name (First Middle Last)	4 years		Mech	anic	al Er	ginee		First, Middle,		. Nav	7	
y carry ould be fi Mental H marked ot	o Be	17. Father's Name (First, Middle, Last)  John Harold A	bell							Mattin	_	orname,		
c, Mal ylan	70	19a. Informant's Name/Relationship (T)			19b. Mailii	ng Addres	ss (Street a			Route Numbe		Town, State,	Zip Code)	
		Patricia C. Abell	/ Wife	lant s				lle S					1D 2077	
		20a. Method of Disposition		e C	Place of Dispo cemetery, crei	matory or	other plac		Dat				r Town, State	
# 그런런 중 .		Donation 5 ☐ Other (Specify)  21. Signature # Funeral Service Licens		Our	: Lady				-26-0			River S Fund	eral Ho	ome.
Depa Impo any is		> Mont d'ulale	sh		2.00					_			MD 210	
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caus ne cause on each a.	ed the deat line. Rena	11		ode <i>o</i> f dyin	g, such as o	cardiac <i>o</i> r r	espiratory arr	rest,		Approxin Interval 8 Onsel ar	Between nd Death
The law requires that the death certificate be executed XIII that been signed by the attending physician and XIII and 25 should be detached for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq										
at the death certific by the attending pi	Physician/M	23b. Was decedent pregnant In the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outc <i>o</i> n 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death 3	⊒Ectopic ⊒ Other (s	pregnancy specify)				23	3d. Date of d Month	elivery Day	Year
w requires that been signed be should be deta	þ	Part II. Other significant conditions co	ntributing to death Mellitus		sulting in the u	inderlying	cause giv	en in Part I.			bacco us		to the cause of	of death?
	Completed								_	24a. Was a autop perfor	sy	24b. Were a prior to death?	autopsy findin completion o	gs available of cause of
Physician: Trips certifical	Be	25. Was case referred to medical examiner?	Hospital:				0#	or:		Check only o				
Phy raid	2	1 ☐ Yes 2 No 27. Manner of Death	1 ( <b>25</b> Inpa		ER/Outpatie		28c. Injur	4 🔲 INUI		d. Describe h			ecify)	
lending eath. or: Afte the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of In (Month, I	Injury - At h	Injury	М	1 🗆	k? Yes 2 □ t	No	f. Location (S	Street and		Pural Route N	lumber,
E Sign		4 ☐ nomicide  29a. Certifier 1 ☑ Certifying Phy	rsician: To the be		owledge, deal						ause(s) a			
To the Hospital within 24 hours a To the Funerell completely filled	Medical	(Check only 2 Medical Exam		of examina										e(s)
To the within To the complex c	Σ	29b. Signature and title or triffer	Bech,	MD		2	9c. Licens	u 605	52	2	29d. Date 3	3   3   4   (Mo.	nth, Day, Yea ) <mark>4</mark>	r)
15		30. Name and address of person who co	CK, M	) 2		Print) Nedi	cal	Pankw	ay (	annap	otis,	MD		
S Regis	tate trar	31. Date filed (Month, Day, Year) MAR 2 9 2004		strar's Sign	ature	وعله								

		1	For State Ragistrar		State	of Ma	aryland	d / Depa <i>Ce</i> a		nt of H			1enta		iene <sub>g. No.</sub> 2 (	004	0947
<u>w</u> 1	4		Decedent's Name	(First, Middle	, Last)								2. Date	of Deatl		Year	3. Time of Death
	ysicia: Nedica		Mildred			Δ1	ease	<b>.</b>		Aı	ndol	eo		ROH	Day 4	200 /	18:17pm
	amine		4a. Facility Name (If I	not institution AGNE	give street and		TAPP	-	4b. City	Town, o		of Death			4c. Coun	ity of Death	
Fun	eral		5. Social Security Nu	mber	6. Sex		e (In yrs. la	st birthday)		er 1 Year		r 24 Hrs.	8. Date	of Birth	Yearl	9. Birth	place (State or Foreign
Dire			215-18-9	191	1□M 2 <b>∑</b> F	=	83	Yrs.	Months	Days	Hours	IVIII).	0.5	02	20		NC
Б. "		ļ	Usual Residence of D				100 City	Town or Lo	nation								10d. Inside City Limits
arylar	N D		10a. State	10b. County													ty∑tyYes 2 □ No
₩ 9E W	1	ecto	MD	NA			Bal	timo		ip Code				10	Og. Citizen o	f What Cou	
036 ours atter death with the Maryland ral', or Itams 23s or 28e-1 show	o a	Director	10e. Street and Num		_				101. 2					"			y 1
s 236	int		3803 Col	borne		ecedent f	Ever in U.S	13	Was Dec		229 dispanic C	Prigin? (Sp	ecity Yes	or No-		S.A.	can Indian,
je 1	Diet.	Š	1 Never Marrie	d 2□ Marri	Armed	Forces?					an, Mexic	origin? (Sp an, Puerto	Rican, e	tc.)	8	lack, White	, etc.
.0036 hours after tural; or Its	TIPE	þ	3 ☑ Widowed 4		If Yes, Year o	es 2011 Give or Dates:			1 🗆 Yes	XXNo	Specif	y:			Spec	eity:	lack
5-00%	edical E			15. Decedent	s Education			16a. Dece	dent's Us	ual Occup	ation	ost of work	rina		16b. Kind of	Business/Ir	ndustry
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Ind 2 be filed atal Hygin		Be	17. Father's Name (F												Maiden Sum		
Marylanc 2 should be f s and Mental is marked of	atic	္	Alfred C			dole	o Sr								ingfi		
2 short and is m	E P		19a. Informant's Nar						•						City or Tow		
(e, M 1 and 2 Health	-	-	Jerome		eo-Son		20h Pt						р Ва Date		more 20c. Location		21229
timore, Pages 1 ar Iment of Heal	5	1	20a. Method of Dispo Magarial 2 ☐		3 Removal fro	om State	- 1	ace of Dispo metery, cre									
timen tent:	injury		4 Donation				Ced						/31/	04	Glen	Burn	ie, Md
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or	any inj		21. Si trature of Fun		Licensee	K	ek	M 4	arch 300	Wab	H We ash	st Ave	Ва	lti	more	Md	21215
Physic			23a. Part 1. Enter the shock, or head Immediate Cause (F disease or condition resulting in death)	Tayure. List	only one cause o	on each iir	the death					las cardiac			est,		Approximate Interval Between Onset and Death
	iner-transit	dicai Examiner	Sequentially list con if any, leading to imr cause. Enter Under Cause (Disease or it that initiated events resulting in death) Li	njury	b Due	to (or as	a consequ a consequ a consequ	ence of):									
X 6 certification	tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nanths?	4□Pr	ve birth	of pregnar 2 Fetal t time of de	death 3[	⊒Ectopic ⊒ Other (:	pregnancy specify)	у					Date of dein Month	very Day Year
rds, P quires that	99	þ	Part II. Other signific		ons contributing t		out not resu CURU		underlying	cause giv	ven in Par	t I.	236		oacco use co os 2□No		the cause of death? bably 4 @Unknown
Division of Vital Records, P.O. Bot or Attanding Physician: The law requires that the death after death.  Director: After this certificate has been signed by the atter Director: After this certificate has been signed by the atter	page 2 should	ompieted												u. Was ar autops perform Yes 2	y ned?	o. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
of Vital B Physician: The	rector, p	BeC	25. Was case referre	ed to medical				/				ce of Dea	th (Check	only on	θ)		
of V Physics	ਰ	٥	1 Yes 2	<b>1</b> 0				R/Outpatie				Nursing H			nce 6 🗆 C		ify)
On O	funera	ü	27. Marry of Death	5 ☐ Pendin	28a. Da	ate of Inju Wonth, Da	y Year)	28b. Time of Injury		28c. Injui Wo			28d. De	scribe ho	w injury occ	urred	
Vision Vision Attending r death.	he fu	atic	2 Accident	investi	gation				М		Yes 2[	□No					
ivisor Att	n by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	determ	nined 28e. P	lace of injusted	jury - At ho tc. (Specify	me, farm, st	reet, facto	ory, office				ation (Sti		mber or Rui	al Route Number,
Di Hospitel or 14 hours afte Funerel Dir	pell			1				university and									
Division  To the Hospitel or Attend within 24 hours after death	stely fi	edical			ng Physician: To Examiner: On the and n		f examinat										
To the within 2	omple	Med	29b. Signature and	title of certifie					2	9c. Licens	se numbe	r		2:	9d. Date sign	ned (Month	Day, Year)
<b>→</b> ₹ ₹	5		16.	1/1	Ken					7	385	43			Mar	ch o	6,2000
			30. Name and addre	wy	who completed	cause of o	leath (Item	23a) (Tuno	Print)						, , , ,		21229
1			KININ K	Scol	1698 111	90		ton	Avel	nue	Bu	1 frm	ear e	N	dry	and	21229
	Stat	e.	31. Date filed (Megt	h Day, Year)	3	2. Registr	rar's Signat		, , ,					•			
Re	egistra	100	MAK &	J 2004	12/20	de la la	1	A.	00- 4	,							

		For State Of State Of Registrar	maryland / Depa <i>Cel</i>	artment of Health and r rtificate of Death	Reg.		09472
Physic		Decedent's Name (First, Middle, Last)     GLADYS E . ASHBY			2. Date of Death Month MARCH 26	Day Yeer • 2004	3. Time of Death
/Med Exami		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or Location of Death		4c. County of Death	
		SUBURBAN HOSPITAL		BETHESDA		MONTGOME	RY
Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 K 7.	Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 3-29-19	9. Birthp Coun 17 VIRG	lace (State or Foreign try) SINIA
р ,		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	postino		1	0d. Inside City Limits
Marylar a-f ehov	Director	MD. PRINCE GEORGE	CLINTON				1)∑Yes 2 □ No
th the	ire	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	itry?
th will		5854 E. BONNIWOOD TURN		20735		USA	
72 hours after death with the Maryland natural", or Itema 23a or 28a-f show alcal Exam nat must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  1 □ Yes 2 If Yes, Give Year or Date	™No	Was Decedent of Hispanic Origin? (S <sub>I</sub> If Yes, specify Cuban, Mexican, Puerti 1 ☐ Yes 2♥ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify: BLA	etc.
72 hours "natural"	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation kind of work done during most of work	king 16b	. Kind of Business/Ind	dustry
within ene.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12) 11  College (1-4	or 5+) life.	DO NOT use retired)	,,,,,g	FOOD SERV	ICE
Hygi other	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Maid	den Sumame)	
d 2 should be file th and Mental Hy to 1s marked oth traumatic event	10 E	MANNING WILLIAMS		ADDIE	GOODMAN		
d 2 should th and Men 7 Is marke traumatic	1	19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street and Number or Ru			
E 77 E		MARILYN J. WILSON(GRAN					
ges 1 and t of Healt If itam 2 or other		20a. Method of Disposition 1 □₹Burial 2 □ femation 3 □ Removal from St	20b. Place of Dispo cemetery, crei	natory or other place)	Date 20c	. Location - City or To	wn, Slate
nit. Pages artment of ortant: If it injury or o		* 4 ☐ Donation S☐ Sther (Specify)	ARBUTUS M	MEMORIAL PARK 4-1-		LTIMORE, M	
permit. Pages 1 a Department of Hee Important: If item eny injury or othe		21. Signature of heral Service Greenee JONATH		Name and Address of Facility PHI 21-27 N. MONROE S			
Physician		23a. Party Enter the disease, or complications that caushook or heart failure. List only one cause or each interediat. Cause (Final	sed the death. Do not ent th line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
/Medical		disease or condition resulling in death)  Due to for	a a consequence of):	~			1
Examiner		Supposite the food distance by	reuma	119			alle.
Sit 6	lner	Sequentially fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):	fract-infe	hins		12.11
be axe rute sicien and burial-transit	I Examine	that initiated events c	as a consequence of):	1 sull 1 get			Wh.
phy:	edical	d					
The law requires that the death certifulate the second control of the law speed signed by the attending age 2 should be detached for use as	Physician/Me		h 2 Fetal death 3 tat time of death 5	Ectopic pregnancy Other (specify)	4	23d. Date of delive Month	ory Day Year
luires that a signed by ald be deta	þ	Part II. Other significant conditions contributing to deal	th but not resulting in the $u$	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to th	
OI VICAL DECOLUS, Physician: The law requires I r this certificate has been signeral director, page 2 should be	Completed	OSteoporo813	,		24a. Was an autopsy performed	prior to cor death?	psy findings available npletion of cause of
ian: Th rifficate tor, pag	a	25. Was case referred to medical		26. Place of Dea	th (Check only one)		
Physician: rthis certific ral director,	OB	examiner? 1 Yes 2 No Hospital: Inc	atient 2 ER/Outpatier	nt 3 DOA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify	1)
ling After	atlon: T	27. Manner of Death  1 Spatural 5 Pending 2 Acciden investigation	Injury 28b. Time o Day Year) Injury	f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	njury occurred	
DIVISION  all or Attending a after death. I Director: After id in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place o building	f Injury - At home, farm, str , etc. <i>(Specify)</i>	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura. tate)	l Route Number,
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C		is of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu			
re th vithin outh	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, I	Day, Year)
->-0		* Kaluan K. T	00.	019609	3.	26.04	
5		30. Name and address if person who completed cause	of death (Item 23a) (Type,	Print) RAMAN	1 R-7	ULI M	Drei
	ate	31. Date filed (Month, Day, Year) 32. Reg	gistrar's Signature	1411-2026	HULFIE	K 17 17 1	20878
Regis		MAR 2 9 2004	Beaswa	& South	**		0 10

Ashby, Gladys 3/26/04 0030 Am

State Registrar

31. Date filed (Month, Day, Year)

I Giveenber

MAR 2 9 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:36 A M Bessie Burd Marc 24 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.

Yrs. Months Days Hours Min. 5. Social Security Number of Maryland 8. Date of Birth Month, Day Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🜠 F -34-167 lirginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10h Counts permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, Its Medical Exacting frout be notified. 28a-f ahow 1 Yes 2 No by Funeral Director 10g. Citizen of What Country? 10s. Street and Number 10f. Zip Code U.S.A 21207 Brive ross 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 25 CNo Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be inknown Dertha Arch bald 19b. Mailing Address (Street and Number or Jural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, 3833 Dout Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 S Burial 2 ☐ Cremation 3 ☐ Removal from State MY ZION Cemelary 30 04 4 Donation 5 Other (Specify) Capton Colory 1911 21. Signature of Funeral Service License Mc Cuffor las 1761 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 🕱 No 4□Pregnant at time of death 5 Other (specify) P.O. | detached 9 Unknown þ signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Be Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 XNo certificate 1 Yes 2 No 1 ☐ Yes Vital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ♀1npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🗙 No 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation within 24 hours after death. To the Funeral Director: 2 Accident the 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier Aman who combleted cause of death (Hem 23a) (Type, Print) 5. d 31. Date filed (Month, Day, Year) South Greene 32. Registrar's Signature State MAR 2 9 2004 Registrar

04-	-02003		Please Tv	pe or Prin	t in Black	Indelible li	nk. Ensure Al	Copies A	re Legible.	
RKI DANIEL	) BRASHI	ΞΑF		State of Ma	aryland / De	partment o	of Health and M	lental Hygi		+ 09475
			Decedent's Name (First, Middle, Last)			_		2. Date of Death Month	Day Year	3. Time of Death
	Physicia		Daniel Br	ashear				MARCH	21, 2004	3:56P. M
	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Tov	vn, or Location of Death		4c. County of Dea	
		•	1928 ½ W.Pratt Stre	et		BALTI	MORE			
200	Funeral Director		214-72-0304	7. Age	9 (In yrs. last birthd 38 Yrs	Months D	ays Hours Min.	8. Date of Birth (Month, Day, Aug. 23,	Year) 9. Bir 1965 Ma:	thplace (State or Foreign ountry) ryland
(4.)	p ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	anyla shov	Ä								1 ves 2 □ No
	h the Marylan r 28a-f show s notified at	Director	Maryland  10e. Street and Number		Do	.ltimore	de	10	g. Citizen of What C	nuntry?
	23a or 2	rai Dir	1928 1/2 West Pratt				21231		United Sta	ates
36	filed within 72 hours after deeth with the Maryland Hygiene ther than "naturel", or Itama 23a or 28a-f show ont, the Madical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Dovorced	. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		I3. Was Decedent if Yes, specify  1 □ Yes 2 □	of Hispanic Origin? (Spe Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
Baltimore, Maryland 21215-0036	72 hours "naturel",	Completed t	15. Decedent's Educat (Specify only highest grade of	tion	1 (6	ecedent's Usual O live kind of work d le. DO NOT use n	one during most of work	ing 1	6b. Kind of Business	Industry
12	withir ane. than	E G	Elementary/Secondary (0-12)	College (1-4or 5	+)	Carpente	·		Construct	cion
9	Hygie ther ther	ပိ	17. Father's Name (First, Middle, Last)		<del></del>	carbence	18. Mother's Name	e (First, Middle, M		
ylan	~ - 0 5	To Be	Carl Russell Brashe	· · · · · · · · · · · · · · · · · · ·			Cecilia			
/ar	2 sh and is m		19a. Informant's Name/Relationship (Type Elizabeth Brashear	•		9 Conley	reet and Number or Rure		Maryland	
0	l and tealth m 27		20a. Method of Disposition						Oc. Location - City or	
0	ges if of H if ite or of		1 ☐ Burial 2 🛭 Cremation 3 ☐ Ren	noval from State	1	sposition (Name o				
Ë	t. Pa tmen tent:		4 □ Donation 5 □ Other (Specify)  21 Signature of Funeral Service Licenses			ash. Cre			Laurel, Ma	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other traumatic any injury or other traumatic and pages.	C	23 art 1. But y he disease, or complica shock, or leart failure. List only		the death. Do not	2134 W11 enter the mode of		Road Du	ndalk, Mai	Inc. CVI and 21222 Approximate Interval Between Onset and Death
	Physician /Medical Examiner	8	Immediate Cause (Final disease or condition resulting in death)		c And Alcoha consequence of):		ation			
M	- M	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):	51				
	s executed en and urial-transit	Examiner	that initiated events							
68760,	te be exe ysicien a se burial-		resulting in death) Last	Due to (or as a	a consequence of):					
P.O. Box 68	Attending Physician: The law requires thet the death certificate be readath.  readath. sector: After this certificate has been signed by the attending physici by the funeral director, page 2 should be delached for use as the by	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregr 5 □ Other (specif			23d. Date of de Month	livery Day Year
ds, P.	v requires thet the been signed by should be detac	d by Ph	Part II. Other significant conditions contri	buting to death bu	ut not resulting in th	e underlying caus	e grven in Part I.	1	acco use contribute to	the cause of death?
Division of Vital Records,	The law requirate has been page 2 should	Completed						24a. Was an autopsy perform 1⊠ Yes 2	ed? prior to death?	utopsy findings available completion of cause of
ta	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Death			
>	ysicl is cer direc	0	examiner? 1 ☑ Yes 2 ☐ No	spital: 1   Inpatie	nt 2 ER/Outpa	itient 3 DOA	Other: 4 Nursing Ho	me 5 Resider	nce 6 Dother (Spe	city) SCENE
o no	tending Physiclan: leath. tor: After this certific the funeral director,	tlon: T	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injur Out Month. Day 372172004	ry 28b Tim	e of 28c.	Injury at Work?	28d. Describe hov Inknown		
)ivisio	or Attendi after death. Director: A in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide		ury - At home, farm c. (Specify)		fice		eet and Number of R State 1928 1/2	wal Royle Number W. Pratt Stree
J	Hospitel	Medical Ce	29a. Certifier 1□ Certifying Physic (Check only one) 1□ Medical Examine	ian: To the best o	of my knowledge, d examination and/o	eath occurred at the investigation, in	ne time, date and place, my opinion, death occurr	and due to the car	use(s) and manner as	stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier			29c. Li	cense number	29	d. Date signed (Mont	h. Day, Year)

State Registrar ANA K
31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUBIO, MD

Apacks ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

MARCH 22, 2004

-			For State Registrer	State of Ma	ryland	l / Depa <i>Cer</i>	rtment of F tificate of	lealth an <i>Death</i>	d Mental I	iygiene Reg. No	2001	. 09	476
			1. Decedent's Name (First, Middle, La	st)	***				2. Date of Month	Death Da	y Year		e of Death
	Physici /Medic		William	Vi	ncen	t		iscoe	MAR	H 2	2 200	4 115	JA M
	Examin		4a. Facility Name (If not institution, giv		20		4b. City, Town, o	TIME		40	. County of De	ath	
6			ST. AGNES HEA			st birthday)	If Under 1 Year		Hrs. 8 Date of	Birth	9. B	intholace (Sta	te or Foreian
	Funeral Director			M 2□F	81	Yrs.	Months Days		Min. (Month	Day, Year)	22	irthplace (Sta Country) MD	
			Usual Residence of Decedent										0. 1
	rylan	_	10a. State 10b. County			Town or Loc							e City Limits fes 2 ☐ No
	Ba-f s	cto	MD NA		Ва	ltimo				10a Ci	tizen of What (		
	with It	Dire	10e. Street and Number				10f. Zip Code	225		109.01	U.S.A	-	
	eath v	Funeral Director	3437 Round Road	12. Was Decedent B	Ever in U.S	. 13. V	1		? (Specify Yes or	No-	14. Race - An	nerican Indiar	١,
"	fter d	Fun	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 N					uerto Rican, etc.	)	Black, Wh		
036	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	□ Yes ***XNo	Specity:				Black	····
5-0	72 hc	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give I	ent's Usual Occup kind of work done OO NDT use retire	during most of	f working	16b. K	(ind of Busines	ss/Industry	
121	within ine. ihan	ld m	Elementary/Secondary (0-12)	College (1-4or 5	+}		sabled	a)			Disabl	.ed	
7	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "naturel", or Items 23s or 28s-f show event, I're Wedical Escritiva must be notified at	ပ္ပ	N/A  17. Father's Name (First, Middle, Last			<u> </u>	300100	18. Mother's	Name (First, Mic				
an	d be ental ked o	To Be	William L. Bri	scoe				Hatt	ie Summ	ervi	lle		
Maryland 21215-0036	should and Men a marke umatic	-	19a. Informant's Name/Relationship (						or Rural Route Nu				
	and 2 salth a rate of tra		Thomas H. Bris	coe-Broth			The second secon		ll Lane	-			
ore.	of He fitterr		20a. Method of Disposition 1☑ Burial 2☐ Cremation 3☐	Removal from State	20b. Pla	ace of Dispos metery, cren	sition (Name of natory or other pla	(0)	Date	20c. L	ocation - City o	or Town, State	Ð
S i	Pag ment ant: I		* 4 Donation 5 □ Other (Special	<del>(y)</del>	Nev		hedral	-	29/04	Bal	timore	e. Md	
S CO E Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examinar must be notified at once.		21. Signature of Funeral Service Lice	Larch		M 4	Name and Address arch F/ 300 Wat	H Wes	t ve, Bal	timo	re Md	212	L5
~			23a. Part1. Enler the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ente	er the mode of dyl	ng, such as ca	rdiac or respirato	ry arrest,			mate Between ind Death
(1)	Physician		tmmediate Cause (Final disease or condition	ANOX	IC E	ENCE	PHALO	PATRI	j			1	DAYS
0	/Medical		resulting in death)	Due to (or as	a consequ	ence of):						19	
· hat	Examiner	L	Sequentially list conditions, if any, leading to immediate	b. SEIZU Due to (or as								11	Dx bs.
Mo	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequi	erice or).							
	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):						<del> </del>	
777 8760	sicien buris	dicai E		. ď									
€89	ificate g phy as the	edic											
- ×	Attending Physician: The law requires that the death certificate be redeth.  refer: After this certificate has been signed by the attending physicie by the funeral director, page 2 should be detached for use as the bur	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnan	ncy death 3 🗆	Ectopic pregnanc	:v			23d. Date of d	lelivery Day	Year
- A	ne deat the ath	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown			Other (specify) _	<u></u>		_	Month	Day	1 Gai
2 - 2 P.O	at the	Phy	9 Unknown			Ning is the	dorhing onuce a	von in Part I	230 [	old tobacco	use contribute	to the cause	of death?
3 %	signed d be del		Part II. Other significant conditions	contributing to death bi	ut 110t 185u	iling in the di	idenying cause gi	veri irr arri.			. □ No 3 □		
oro	v requi	Completed							242 \	Vas an	24h Were	autopsy findii	nns available
ec Sec	has has by 3e 2 s	mp					<del></del>		- a	utopsy erformed?	prior t death	o completion?	of cause of
a	n: Th ficate or. pag	e Co	25. Was case referred to medical					26 Place of	1 ☐ Y		1 1 1	es 2 No	
5	s cert	To Be	examiner?	Hospital: 1 Alnoatie	ent 2 🗆 E	ER/Outpatien	t 3 DOA Ot	bor	ing Home 5 ☐ F		6 ☐Other (Sp	pecify)	W. W.
ō	g Phy er this eral c	L:	27. Manner of Death	28a. Date of Inju	ry	28b. Time of Injury	28c. Inju				iry occurred		
lo	nding ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	n	, , , ,	111,017		Yes 2 □ No					
Division of Vital Record	al or Attend after death   Director: / d in by the f	Certification;	3 Suicide 6 Could not to determined		ury - At hor c. (Specify)	me, farm, str	eet, factory, office			on (Street a Town, Stat	nd Number or . e)	Rural Route I	Vumber,
Q	itel or irs afte rel Dir												
	Hosp 4 hou Fune lely fil	Cal	(Check only 2 Medical Exa	miner: On the basis of	f examinati	vledge, death ion and/or inv	occurred at the trestigation, in my	ime, date and p opinion, death	place, and due to occurred at the ti	the cause(s me, date an	s) and manner d place, and d	as stated. ue to the cau	se(s)
	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29b. Signature and title of certifier	and manner sta	2.60.		29c. Licen	se number		29d. Da	ate signed (Mo	nth, Day, Yea	ar)
	F 3 F 8		Venzuncia	m			Pi	760	0	03	122/0	4	
			3	,	leath (Item	23a) (Type,				1			10 00
	2		DrNIRUSAMA M	completed cause of d	FAGN	IES HE	EAZTH (	ARB 9	100 CHTON	VAV6	SALTI	MORE!	MD-2122
	St	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	ure							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 0.01.

			1 - State Registrar	State of Man	yland / Depa <i>Cel</i>	artment of H rtificate of L	eaith and iv D <i>eath</i>		enez U () 4	09477
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	·	3. Time of Death
	Physici /Medio		Frances E. Char	rch				March	27 2004	1:15 a M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			Heritage Nursing			Dundalk	(f ) Indos 04 Hsa		Baltimo	
	Funeral		5. Social Security Number 6. Sec	M 21XF 7. Age (	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		218-01-2279 Usual Residence of Decedent	90				Aug 22,	1905   Loui	siana
	yland		10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
	a-1 s	ctor	Maryland n/a		Baltin	nore				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Cou	-
	ath w		1936 Harman Avenue			1	230		United Sta	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tat Hygjene. d other than "natural", or tlems 23a or 28a-1 show event, the Medical Examinar must be notified at	by Funerai	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (Spin, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
ŏ	2 hou	ted	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occupa	ation	1	6b. Kind of Business/Ir	ndustry
218	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired,	)	ing		
7	filed wi Hygien sther th	Co	12		Lá	ab Tester			alvert Dis	tillery
ind		Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
3	d 2 should be th and Mental 7 Is marked o traumatic eve	ဥ	Anthony Charch  19a. Informant's Name/Relationship (Ty	no Print)	10h Mailie	a Address (Street s		Concaslae	City or Town, State, Zij	Codol
Z	12 s h ar 7 ls rrau		Sandra Hoskins / I	•					ore, Maryla	
			20a. Method of Disposition		20b. Place of Dispo				Oc. Location - City or T	
υOπ	ages ant of at: If i		1 X Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Woodlawn		1	2004	Woodlawn, I	Marvland
Baltimore,	permit. Pages 1 a Department of He- Important: If item any Injury or othe		21. Signature of Funeral Service License	98	22	. Name and Addres	s of Facility Hu	bbard Fu	neral Home more, Mary	, Inc.
	744		23a. Part1. Enter the disease, or compl	cations that caused the						Approximate Interval Between
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. ATHER	COSCER consequence of): CRBL VI	OF/C	CARDIL	NASC	CULAR	Interval Between Onset and Death
	Examiner			RERIPHI	RAL W	15/211 A	2 17551	ASE I	436738	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a o	consequence of):					
	ifficate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events	MAEN	18)					
30,	oe execian a		resulting in death) Last	Due to (or as a c	consequence of):					
68760,	cate b	edical		DETRE	>5/07					
P.O. Box 6	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
	uires that i signed by Id be deta	þ	Part II. Other significant conditions con	ntributing to death but r	not resulting in the u	nderlying cause give	en in Part I.		acco use contribute to t	
Division of Vital Records,	. The law requir cate has been si page 2 should	Completed						24a. Was an autopsy perform	prior to co	ppsy findings available impletion of cause of
ital		0	25. Was case referred to medical				26. Place of Deatl	1 ☐ Yes 2	¶2No 1 ☐ Yes	2 <b>/2</b> No
	nysici Nis cel direc	To B	examiner?	lospital: 1   Inpatient	2 ER/Outpatien	t 3 DOA Othe	or: 4 D wursing Ho	me 5 Resider	nce 6 Other (Special	(y)
ion o	Attending Physician: r death. sctor: After this certific by the funeral director,		27. Mann Death 1 Atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. injury Work M 1 🗀	at ? ∕es 2 □No	28d. Describe hov	w injury occurred	
Divis	in Little	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical			camination and/or inv				use(s) and manner as s te and place, and due t	
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Month,	Day, Year)
	Į.		Saurude 1	JUDE	6 ND	D2.	7/88		3/29/0	4
	5		30. Name and address of person who co	ompleted cause of deat	th (Item 23a) (Type, 2 May s Signature	Print) Net F	Gue D	undak	MD 2/	222
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Soul				

**Physician** /Medical

Examiner

31. Date filed (Month, Day, Year)

9 2004

**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Rems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Tv	ype or Print in Black In	delible Ink. Ensure A	II Copies Are	Legible.	
=	State of Maryland / Depart				09478
Decedent's Name (First, Middle, Last)	0		2. Date of Death Month De	/ Yeer	3. Time of Death
Charles Will	iam Chamber	8	MARCH 23,2	004	5:00 P M
4a. Fecility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death	4c.	County of Death	1
5. Social Security Number 6. Sex	Valley Way  7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	* Birthol	eca (Stete or Foreign
	M 2□F (22) Yrs.	Months Days Hours Min.	(Month, Day, Year)	Count	iry)
Usual Residence of Decedent	10.00.7			1	Od. Inside City Limits
10a. State 10b. County	10c. City, Town or Lo	and and		"	1 ☐ Yes 2 ☑No
10e. Street and Number	x Cagette	10f. Zip Code	10g. Cit	izen of What Count	try?
1302 A CLOVE	0 Vallage 11 Vall	21040		1184	
11. Marital Status	2. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America Black, White, e	
1 Never Married 2 Married	1 TXYes 2 TNo	1 Yes 2 No Specify:	Thour, Go.,	Specify: / 1 /4	:Lo
3 Widowed 4 Divorced	Year or Dates:	dent's Usual Occupation	16b K	ind of Business/Ind	luetov
15. Decedent's Education (Specify only highest grade	completed) (Give	kind of work done during most of work DO NOT use retired)	ing lah	40 HARVI	18-Bayview
Elementary/Secondary (0-12)	College (1-4or 5+) Regi	istered Nurse	2011	res right	
17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maiden	Sumame)	
Rothchild Cl	rampers	IVIAR	y canto	ucel	
19a. Informant's Name/Relationship (Typ	e, Print) 19b. Maili	ng Address (Street and Number or Rui	al Route Number, City of	Town, State, Zip	ALL SINCE
20a. Method of Disposition	20b. Place of Dispo		9 10 10 20c. Lo	cation - City or To	Mn, State
1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify)	moval from State	matory or other place) Ball Mark	has Fal	cd 410	MD
21. Signature of Funeral Service License	e , // 21	2. Name and Address of Facility	ANS FINOR	al Chara	0
KRIJGALIK	Jella 3	"HEWOORT DR. F	DREST HELL	MD 21	1050
23a. Fart1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Immediate Cause (Final disease or condition	METASTATIC ESOPHAC	GEAL CANCER		(U)	Onset and Death
resulting in death)	Due to (or as a consequence of):				
Sequentially list conditions, b.	Due to (or as a consequence of):				
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 to (01 45 4 05 15 4 2 5 1).				
resulting in death) Last	Due to (or as a consequence of):				
L d.					
IF FEMALE:					
23b. Was decedent pregnant in the past 12 months?		⊒Ectopic pregлалсу		23d. Date of delive Month	ry Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 5 [ 9 □ Unknown	Other (specify)			
Part II. Other significant conditions conf	tributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco (	use contribute to th	e cause of death?
			1 ☐ Yes 2	□No 3□Proba	abiy 4 ⊠Unknown
			24a. Was an autopsy	24b. Were autop	osy findings available inpletion of cause of
			performed?	death?	
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)		
1 ☐ Yes 2 🛣 No	ospital: 1 Inpatient 2 ER/Outpatie		ome 5 Residence		)
27. Manner of Death 1    1    Natural 5   Pending	28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injur	ry occurred	
2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, st		28f. Location (Street ar	nd Number or Rurai	l Route Number,
4 Homicide determined	building, etc. (Specify)	,	City or Town, State	)	
	ician: To the best of my knowledge, deat				
(Check only 2 Medical Examin one)	er: On the basis of examination and/or in and manner stated.				
29b. Signature and title of certifier		29c. License number		te signed (Month, L	
-JK-Wala	called mo	0005950	2 MARC	Н 25,2004	4
30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type.	, Print)			_

Registrar

DHMH 17 Rev 1/2001

State

JYOTI WALAVALKAR, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD., 21902

em		1	For State Registrar		State of Ma	ryland /	Depa Cen	rtment of l	Health and Death	Mental Hy	/giene Reg. No.		09	479
			1. Decedent's Name	(First, Middle, Las	t)					2. Date of D Month	eath Day	/ Year	3. Time o	f Death
	Physicia				Lind	la Elea	anor	Church		March	21		7:33	3 A <sup>M</sup>
	/Medica Examine		4a. Fecility Name (If	not institution, give	street and number)			4b. City, Town,	or Location of Dea	th	4c.	County of Deat	h	
	LAGITITIE		Johns Hopl	kins Bayv	riew Medica	l Cen	ter	Balt	imore			N/A		
	Funeral		5. Social Security Nu			(In yrs. last	$\rightarrow$	If Under 1 Year			irth	9. Birt	hplace (State untry)	or Foreign
	Director		220-66-00	075	□ M 2*CD\$F 4	8	Yrs.	Months Days	Hours Mir	Dec.	20,19	955 Ma	ry1and	l .
			Usuel Residence of										444.004.6	25-11-5-
	yland		10a. State	10b. County		10c. City, To	own or Loc	cation					10d. Inside 0	
	Mar	ם ו	Maryland	Balt	more				Dι	ındalk			1 ( 10	s 2*⊡ No
	r 28	Le	10e. Street and Num	nber				10f. Zip Code			10g. Citi	izen of What Co	untry?	
	3a o	Funeral Director	1816 Ty	ler Road					21222		Uni	ited Sta	ates	
	deati	Jer.	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13. W	Vas Decedent of	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or N	0-	14. Race - Ame Black, White		
ယ	or its	2	1 Never Marrie	ed 🍇 🖾 Married	1 ☐ Yes 24 ☐ N	0		☐ Yes XX No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify:	White	دِ
21215-0036	within 72 hours after death with the Maryland sne. than "naturat, or iteme 23s or 28s-f show the Madical Examinar must be multified at	ò	3 Widowed	4 Divorced	If Yes, Give Year or Dates:							opoony.		
9	72 ho	Completed	(Sneci	15. Decedent's Ed	lucation de completed)	1	6a. Deced	ent's Usual Occu	ipation e during most of w ed)	orking	16b. Ki	ind of Business/	Industry	
21	thin 7	ᇍ	Elementary/Secon		College (1-4or 5-	+)								
2	filed withi Hygiene. other than	5	12 Years	s			Pu	rchasin				lerica1		
	be file ital Hy od oth	Be	17. Father's Name (	First, Middle, Last)						ame (First, Middl		Sumame)		
<u> a</u>	Aentz Aentz rked tic e	9	Melvin	Houck						nor Heim				
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M		19a. Informant's Na			1			at and Number or F					
	and 2 Balth a n 27 is		Mr. Dona	ld J. Chu	irch / Hus	band	1816	Tyler	Road Dui		,			
5	f He item		20a. Method of Disp			20b. Place ceme	e of Dispos etery, crem	sition (Name of natory or other pl	ace)	Date	20c. Lo	ocation - City or	Town, State	
E	Pages nent of int: If it			_Cremation 3 _ 5 ☐ Other (Specification)	Removal from State	Oak :	Lawn	Cemeter	y 3/25/2	2004	Ba	altimore	e, Mary	'land
Baltimore,	그 든 큰 글	1	21. Signature of Fu	neral Service Licer	1866		22	Name and Add	ress of Facility k Funera	Home o	f Dur	ndalk -	Inc.	
Ã	Departiment in poor in		Veed	1/1/4					e Ave. I					
5.			23a Part 1. Enter th	ne disease or com	plications that caused	the death. [	Do not ente	er the mode of dy	ring, such as cardi	ac or respiratory	arrest,		Approxima Interval Be	ate etween
	Dharisian		Immediate Cause (	(Final	one cause on each lin			/	2-1:04				Onset and	
	Physician /Medical-		disease or condition resulting in death)	n	Due to (or as	29 T	HROM	(BOEM!	SOLISII					
NE.	Examiner							TH ROM	20015					
		- G	Sequentially list con	nditions, nmediate	b. DEEP Due to (or as a	VENO a consequen	ice of):	PROIT	1303/3					
	ted	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	rfying injury	. ANKLE	500/70/	BE	WITH	SURGI	CALR	FOA	IR		
	ate be executed the burial-transit	xar	that initiated events resulting in death) L		C. Due to (or as	a consequen		00 ( ) [ ]	3 4/001	4,6	<u> </u>			
8760,	be e icien buria	ical E												
387	certificate be executed iding physicien and ise as the burial transit	dic		-	d									
9 ×	eath certific attending p	Physician/Med	IF FEMALE:		23c. If yes, outcome	of pregnancy	,					23d. Date of de	iverv	
Вох	death e atten	lan	23b. Was decedent in the past 12	months?	1☐Live birth 4☐Pregnant at	2 Fetal de	ath 3	Ectopic pregnan Other (specify)	су			Month	Day	Year
-	tt the de by the tached	yslo	1 □ Yes 2 □ 9 ☑ Unknown		9□ Unknown									
P.0	that the ed by detac				contributing to death bu	ut not resultir	ng in the ur	nderlying cause g	given in Part I.	23e. Dio	tobacco u	use contribute to	the cause of	death?
ecords,	8 E 8	þ								1	Yes 2	<b>⊠</b> No 3□Pi	obably 4	]Unknown
0	w require been si should?	Completed								04- 146		245 144000 00	stance finding	a musulable
ec	a 2.0	ğ								24a. We	opsy formed?	prior to death?	topsy finding completion of	cause of
E.	Th ate pag	Co									2 No		2 🗆 No	
of Vital	Physician: The this certificate aldirector, pag	Be	25. Was case refer examiner?	red to medical						eath (Check only	one)			
>	8 v F	2	1 X Yes 2 □	No	Hospital: 1 ☐ Inpatie			1 SLI DOA		Home 5 ☐ Re			city)	
0			27. Manner of Deat 1 □Natural	h 5 🗌 Pending	28a. Date of Injui	(Year)	3b. Time of Injury	W		28d. Describe		AD FALL	form !	MAN
Ö	Attending r death.	atic	2 Accident	investigatio	- ( 6 / 6	14 V	NKNO	1 1	Yes 2 No	3013160	1 n	MU TALL	T POINT	A Dre A
Division	Atte	tiflo	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		ury - At home c. (Specify)	e, farm, stre	eet, factory, offic	Θ	City or T	own, State			
D	spital or ours afte nerel Dir filled in	Certification:				SIDE	NCE			1816 TG	LER	RD, DUN	IDALL	, MD
	nour uner		29a. Certifier	1 Certifying Ph	nysician: To the best	of my knowle	edge, death	occurred at the	time, date and pla	ce, and due to th	e cause(s	) and manner as	s stated.	(s)
1	To the Howithin 24 h	edical	(Check only one)	X Medical Exal	and manner sta	ated.	i and or in	vosugation, in m)	Opinion, death oc	veriou at tile time				
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Ň	29b. Signature and	title of certifier	<b>b</b>				nse number			te signed (Mont	-	
	1		▶ ()	mes L				0	.C.M.E.		Marc	ch 22, 2	2004	
	11/		30. Name and addr	race of parson who	completed cause of d	eath (Item 2)	3a) (Type	Print)						

State Registrar

31. Date filed (Month, Day, Year) NAR 2 9 2004

ANA

RUBIO, MA

ar)

9 2004

32 Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

			1- Statement Item#12,per		Marylan 5/04.cc	d / Depa	artmeni rtificate	t of H	ealth a Death	ınd M	lental Hy	/giene Reg. No.	200	4 09480
E	Physici	an	Decedent's Name (First, Middle, La:     CLARENCE		ADDIE	TD		_			2. Date of De Month	Day	Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, given PRINCE GEORGES H	street and numb			, ,	Town, or	Location of	f Death	03- 2		County of Dea	5:20P M GEORGES
े हो अ	Funeral Director		100 02 1000	ex M 2□ F 7.	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 06-24-	rth ay, Year)		thplace (State or Foreign ountry) FL
300.00	Maryland a-f show	tor	Usual Residence of Decedent  10a. State  10b. County  MD  P.G.			y, Town or Lo		IT						10d. Inside City Limits 1X Yes 2 □ No
	with the	Director	10e. Street and Number 120 68TH PLACE				10f. Zip	Code 20743				10g. Citize	en of What Co	ountry?
9003	filed within 72 hours after death with the Maryland thygiene. ther than "natural", or ttems 23a or 28a-f show int, the Medical Exerticer transite recitied at	d by Funerai	11. Marital Status  1 Never Married 27 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 2 Yes 2 If Xes, Give Year or Date	ent Ever in U. es? No1963- es: 63-6	-69		ent of His		in? (Spe Puerto I	ocify Yes or No Rican, etc.)	1	USA 4. Race - Ame Black, Whit Specify: BLA	e, etc.
21215-	be filed within 72 ho tal Hygiene. d other than "nature.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) 3YRS llege (1-4	or 5+)	16a. Deced (Give life. L	kind of won DO NOT us	k done di e retired)	uring most	of workir	ng		d of Business	Industry
yland;	e de la B	To Be C		LE, SR.					ELL	A MA	(First, Middle	, Maiden S	Sumame)	
Baltimore, Maryland 21215-0036	1 and 2 s Health ar em 27 is ther trau		MARVA L. CHAPPLE  20a. Mathod of Disposition	/WIFE			68TH	PLAC	E, SE	AT F	I Route Numb PLEASAN ate	T, MD		-2103
<b>3altim</b> c	permit. Pages Department of Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	<i>'</i> )		ELTENH	AM VE	T. C	EM   0		0/2004 ES A. M		TENHAM	, MD S F.H., INC
4	00780		23a. Parl 1. Enter the disease, or compshock, or heart failure. List only	plications that cau	sed the death		1/01	LAUK	ENS S	TREE	T BAL	то	MD 212	17 Approximate Interval Between
8760,	death certificate be executed  A seattending physician and attending physician and attending physician and for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, trauming to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or b. Due to (or	as a consequal as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequ	uence of):	In	jar	ctio	1				Onset and Death
P.O. Box 68	death certifi e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ∏ Fetal tat time of de	death 3	Ectopic pre Other (spe					23	d. Date of deli Month	very Day Year
	w requires that the been signed by the should be detache	ed by P	Part II. Other significant conditions of Ity pertension	1		Iting in the un	derlying ca	use giver	in Part I.			obacco use Yes 2 🗀		the cause of death?
al Reco	The law ate has b page 2 s	Completed by		erolem	19						24a. Was autop perfo 1 Yes	an osy rmed? 25 No	24b. Were au prior to c death? 1  Yes	topsy findings available ompletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	ition: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpa 28a. Date of In (Month, in	-	ER/Outpatient 28b. Time of Injury		Other c. Injury a Work?	4 □ Nurs	sing Hom	(Check only o	dence 6 [		ify)
Divis	tal or Atter	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At hor etc. (Specify,	me, farm, stre	et, factory,	office		28	8f. Location (S City or Tow	Street and I vn, State)	Number or Ru	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in It.	Medical	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the be iner: On the basis and manner	or examinati	vledge, death on and/or inv	estigation, i	n my opir	nion, death	place, ar occurred	nd due to the o	cause(s) and date and pl	nd manner as ace, and due	stated. to the cause(s)
	5 × 5 × 5		29b. Signature and title of certifier  Buth  Control  Con					DOC	1576	680		-	igned (Month	
	10			pan	Kaise	ER-S	(rint)	Aut	h W	lay	Mar	low f	dghts, 1	ND 20746
	Sta Registra		31. Date filed (Month, Day, Year) MAR 2 9 200	32 Regi:	strar's Signati	ure	A.C.			/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 4 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 28 2004 3:02 A Dresner Mary Frances /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Drive Clarksville Howard 11840 Chapel Estates If Under 1 Year If Under 24 Hrs. Months Days Hours Min. March 24, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) **Funeral** 1 □ M 250 F 1941 Maryland 214-38-8666 63 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Clarksville Director Maryland Howard 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number Estates 21029 United States 11840 Chapel Drive Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2√3√No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 0 1 ☐ Yes 2 ☐ No White Specify: ۵ 3 ☐ Widowed 4 ☐ Divorced natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Jenny s 1 and 2 should be of Health and Mentical Item 27 is marked George Kochol ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David A. Dresner - Husband 11840 Chapel Estates Drive Clarksville, MD 21029 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 a
Department of He
Important: If Item
any injury or oth 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/31/04 Balt. Wash. Crematory Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses 22. Name and Address of Facility.
Gary L. Kaufman Funeral Home At MMP., 7250 Washington Blvd. Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Neumon **Physician** resulting in death) /Medical or as a consequence of): **Examiner** eutro Sequentially list conditions, if any leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner nocytic Leutenia 23 years burial-transit and attending physician Physician/Medical as the Box ( IF FEMALE use If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ło in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2. No Be Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 Yes 1 Yes 2€ No certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 | Homicide or / within 24 hours a To the Funeral I Pelli ī Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ihe e 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature apd-title of certifier 2360 elevary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA, MD MARYLAND ORLOLOGY CENTER

State Registrar

DHMH 17 Rev 1/2001

MAR 2 9 2004

EDWACO LEE, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

CENTRAC

		_ 1	For State Registrar	State of Marylar		artment of Hertificate of E			iene 2004	09482
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	h Day Year	3. Time of Death
-	Physicia /Medic	_	Robert Eugene		Dought	у		March 2		11:50 A M
,	Examin		4e. Facility Name (If not institution, give st	eet and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
			Chesapeake Hospi	ce House		Linthicu			Anne Arun	
	Funeral Director		5. Social Security Number 142-12-3174 6. Sex	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month Day, Dec 16,	1923 9. Birt	hplace (State or Foreign untry) NJ
	pur *	-	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty. Town or Lo	cation				10d. Inside City Limits
	sho	2	MD Anne Ar	undol	Glen B	urnio				1 ☐ Yes 2 ☑ No
	28a-f	ect	10e. Street and Number	unacı	arch b	10f. Zip Code		10	Og. Citizen of What Co	untry?
	with a or	ă	105 号 First Avenue	W			061		U.S.A.	
	ns 23	era		. Was Decedent Ever in U	I.S. t3.	Was Decedent of His II Yes, specify Cubar		ecify Yes or No-	14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show aimportant: if Item 27 is marked other than "natural", or Items 20 or 28a-f show aimportant or other traumatic svant, I'm Medical Examiliar must be notified at ance.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1√ Yes 2 □ No If Yes, Give Year or Dates:		ll Yes, specify Cubar 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, White Specify: W	hite
ŏ	2 hou	ed d	15. Decedent's Educa	ation		dent's Usual Occupa kind of work done d			16b. Kind of Business/	Industry
215	Med 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	ing most of work	arry		
2	d with	E O	11		Forem	ian			Sheet Meta	1
פ	e filed al Hygi i other vent, I	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, N		
<u> a</u>	should be and Mental marked o umatic svs	To I	William Doughty				lher	esa Pric	e	
Maryland 21215-0036	2 sho and l		19a. Informant's Name/Relationship (Typ	e, Print)	1 5	20 1 20 1	33 To 2		City or Town, State, 2	
	1 and 1eaith em 27 ther tr		Mrs. Shirley Gibson 20a Method of Disposition	/ Neice	309 Place of Dispo	High Eock sition (Name of matory or other place	_load B		MD 2122 20c. Location - City or	
Baltimore,	Pages nent of h ant: If its ary or of		1 ☐ Burial 2 ☐ Cremation	moval from State			· i riai	ch 27	Clas Bussi	o MD
턡	it. Partmet		'4 ☐Donation 5 ☐ Other (Specify)  21. Signature of Fining all Service Li¢ens	IG16	n Have	n Memoria	] Park	2004	Glen Burni	e, MD
Ba	Depa impo any i		1 Minus	cellas Moiz	xy + 1	Second A	venue, S	.W. Gle	Funeral Ho n Burnie,	MD 21061 Approximate
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the deal cause on each line.	th. bo not en	(2.)	e Obali	. r O 1	1200) 150D	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of:				10	
	-	e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
o,	te be executed ysicien and ie burial-transit	Exa	resulting in death) Last	Due to (or as a conse	quence of):					
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9 ×	ertific ling p	Mec	IF FEMALE:	c. Il yes, outcome of pregn	00001					
Вох	death certifica e attending ph id for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	ai death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	Day Year
o.	res that the de signed by the a l be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	Ogalli J					
Δ.	that t ed by detai		Part II. Other significant conditions conf	ributing to death but not re	sulting in the u	inderlying cause give	n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Records,	w requires that the sbeen signed by the should be detached	d by	De Fostate	Colena	ence			1 ☑ Ye	s 2 No 3 Pr	obabiy 4 DUnknown
Ş		Completed	ţ					24a. Was ai		stopsy findings available completion of cause of
Re	0 = 0	E O						autops perform		-
tal	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	th (Check only on		1025A
$\leq$	S D	0	examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatie	nt 3 DOA Othe	or: 4 Nursing H	ome 5 Reside	ence 6 Other (Spe	city) tolk
10	ig Phy ter thi	n: T	27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injury Work	at (?	28d. Describe ho	w injury occurred	
Ö	Attending r death. ector: After by the fune	atic	2 Accident investigation			M 1 🗆 '	Yes 2□No			
Division of Vital	after de Direct	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st ify)	reet, factory, office		281. Location (St. City or Town	reet and Number or Ri n, State)	ural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C		ician: To the best of my kner: On the basis of examinand manner stated.						
	To the I within 2. To the I complet	Med	29b. Signature and title of certifier	and marmor states.		29c. License	number	29	9d. Date signed (Mont	h, Day, Year)
	8 ∓ 8		Mund	1 Do		1	3)(7	0,	Mercho	42104
	1		30, Name and address of person who con	upleted oause of death (Ite	m 23a) (Type	Print)	1131	,	70000	1: 20-1
	1.	)	Chesalla De	heno,	305.	H850.7	ed Drive	8 5to	n Burney	Md. 2106/
SA.	Sta Regist	ate	31. Date liled (Month, Day, Year)	32 Registrar's Sign	nature			/		,

			For State Registrar	State of Maryla		ent of Health and I ate of Death	Mental Hygie	- 2 H H I I .	09483
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last William Ar. 4a. Facility Name (If not institution, give	thony Do	auber	city, Town, or Location of Death	2. Date of Death Month	Day Year Year Year Year Year Year Year Year	3. Time of Death
	Funeral Director	C.	1202 Athens 5. Social Security Number 6. S 212-16-4655 7	Court		BelAir nder 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye MACCh 29,	Harford	d County  lace (State or Foreign  ry and
	the Maryland 28a-f show	ector	Usual Residence of Decedent  10a. State  10b. County  Maryland Harfo	rd Co. 10c. c	ity, Town or Location				0d. Inside City Limits 1 □ Yes 2 No
	within 72 hours after death with the Maryland ene. Than "natural", or itams 23a or 28a-f show ita Medical Examiner must be notified at	Funeral Director	10e. Street and Number  1202 AHUEUS  11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was De	Zip Code  Z 10 14  acedent of Hispanic Origin? (Sippecify Cuban, Mexican, Puert	pecify Yes or No-	Citizen of What Coun	an Indian,
21215-0036	n 72 hours after "natural", or it edical Exa⊤im	by	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest gra	1 Yes 2 No If Yes, Giver Year or Dates:	1 ☐ Ye	s No Specify:	16h	Specify: White, Specify: W.	ite
S	filed Hygi thar ant, t	Be Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	Coilege (1-4or 5+)	Aircrat	work done during most of work Tuse retired MCChanic	e (First, Middle, Maid	Martin 1	Aircraft
Maryland	2 should and Mer is marka aumatic	ToB	19a. Informant's Name/Relationship (7	Daubel you Print) Daugn	9b. Mailing Addr	ess (Street and Number of Ru	Seral Route Number, Cit	yor Town, State, Zip	Code)
Baltimore, I	es 1 an of Heal f itam 2 r othar		20a. Method of Disposition  1 Burial 2 Cremation 3 Cremation 3 Other (Specify	Removal from State	Place of Disposition (cometery, cramatory)	Name of or other place) BAIC 3.	Date 20c.	Londition - City or To	2/0/4 wn, State H. // MID
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	· Jan, Sr	Peac 73	and address of Japilly	atives fur Timor	neral + Crei	mation Center
	Inysician /Medical		23a. Fatt. Enter the disease, or compense, or heart failer. List only of immediate Cause (Final disease or condition resulting in death)	a	Kms	node of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between On and Death
60,	icate be executed  physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.	<sub>ໄປປົ</sub> ກເອ ປ່ີງ.				
Box 6	death certif e attending id for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregni 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	il death 3 □Ectopic	pregnancy (specify)		23d. Date of deliver Month	y Day Year
ords, P	w requires that the been signed by the should be detache	ρχ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	g cause given in Part I.		use contribute to the	e cause of death?
I Rec	The faw te has b	e Completed	25. Was case referred to medical					prior to com	sy findings available pletion of cause of
o	After this funeral d	ToB	examiner?  1	Hospital: 1   Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury M	DOA Other: 4 Nursing Ho	me Residence 28d. Describe how inj	6 ☐Other (Specify) ury occurred	
Divi			3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	y)		28f. Location (Street a City or Town, Sta	te)	
	To the hospital or within 24 hours after to the Funeral Dir. Completely filled in 1	Medical	(Check only 2 Medicel Examone)  29b. Signature application of certifier	ner: On the basis of examina and manner stated.	tion and/or investigati	ed at the time, date and place, on, in my opinion, death occurr 29c. License number	ed at the time, date a	s) and manner as stand place, and due to the signed (Month, Date of the signed (Month, Date of the signed (Month, Date of the signed (Month, Date of the signed (Month, Date of the signed of the sign	he cause(s)
	10		30. Nante and address of person who c	ompleted cause of death (Item	23a) (Type, Pfint)	20742	73	129/	04
	Sta		31. Date filed (Month, Day, MAR 2	9 200 Alegistra Signal	RAV				

			1 - For State Registrar	State of Man	yland / Dep <i>Ce</i>	artment of Hortificate of E	ealth and Death		iene 200	4 09484
	Physici /Medi	cal	Decedent's Name (First, Middle, Last Maggine     Maggine     As. Facility Name (If not institution, give	I	avis	4. 6.		2. Date of Dea Month	26,200°	1:50 AM
The State of	Examir Funeral Director	ier	5. Social Security Number 6. Se 216–12–3164	ay View Co	n yrs. last birthday) Yrs.	4b. City, Town, or  But  If Under 1 Year  Months Days	If Under 24 Hrs Hours Min	8. Date of Birth		rthplace (State or Foreign outry)
	ehow	o.	Usual Residence of Decedent  10a. State 10b. County	11	Oc. City, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	with the N a or 28a-1 be notifi	Director	Md. NA 10e. Street and Number		Baltim	10f. Zip Code		1	0g. Citizen of What C	
9036	n 72 hours after death with the Maryland "natural", or Hems 23a or 28a-1 show ledical Examinst must be notified at	d by Funerai	5415 Omaha Ave.  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		21206 Was Decedent of His If Yes, specify Cuban 1 Yes X No	spanic Origin? (S , Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	USA  14. Race - Am Black, Wh  Specify: B	
Maryland 21215-0036	c * 6	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done di DO NOT use retired)	uring most of wo	rking	16b. Kind of Business	
land 2	be filed Ital Hygi of other	To Be Co	4th grade 17. Father's Name (First, Middle, Last) Hampton	P. (1997)	Smith	hine Opera		me (First, Middle, I	Domino S Maiden Sumame) Workma	
	2 sho and Is m	ī	19a. Informant's Name/Relationship (Ty Marie Davis	<sub>ре, Print)</sub> Daughtei	19b. Mailie	ng Address (Street ar 5 Omaha A			City or Town, State,	
Baltimore,	m O		20a. Method of Disposition  1 Description   1 Description   2 Description   3 Description   5		20b. Place of Dispo cemetery, cres		)	Date	20c. Location - City or Arbutus ,	
Balti	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Licens	10 and	22	Name and Address	of Facility	Ba	ltimore, North Ave	ld. 21202
8760,	death certificate be executed  We attending physicien and eattending physicien and of for use as the burial-transit	icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fary, loading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	Dissequence of):	er the mode of dying,	such as cardia	c or respiratory arre	sst,	Approximate Interval Between Onset and Death
P.O. Box 68	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
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Vital Records,	sician: The law i certificate has bi rector, page 2 sh	e Completed	pulmonary dista 25. Was case referred to medical	st cance use	C, Chri	nic obs	trictly	24a. Was ar autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
Division of Vi	ding Phys	To B	examiner?	ospital: National 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien  28b. Time of Injury	t 3 DOA Other: 28c. Injury a Work?	4 🗆 Nursing H	ome 5 Reside 28d. Describe ho	nce 6 Other (Spe	cify)
Divis	tal or Atters after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one) (Certifying Physical Certifying Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Certification Physical Ce	ician: To the best of m ler: On the basis of exa and manner stated.	y knowledge, death amination and/or inv	occurred at the time estigation, in my opin	, date and place nion, death occu	, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
ı	To To Con	Σ	29b. Signature and title of certifier	Am.	mp	29c. License r			d. Date signed (Mont.)	
	Ŋ Sta		30. Name of address of person who co	32. Régistrar's	05 HOPE	uns By	view (	Circle!	BALTIMORE,	6, 2004 MDZ1224
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	/Medic Examin		4a. Fecility Name (If not in		give stree	et and nun	n <i>ber)</i>					Location of	of Death		1	. County o		l	
33%	Funeral Director		5. Social Security Numbe 214–94–1543		5. Sex 1 ☐ M			In yrs. Ia 39	st birthday) Yrs.	If Under Months		if Under Hours		8. Date of Bir (Month, Da July 1	th Y. Year)	964	9. Birthp Coun Vil	lace (State of try) Ginia	r Forei <b>gn</b>
	land ow		Usuel Residence of Dece 10a. State 10b.	. County			1	Oc. City,	Town or Lo	ocation							1	0d. Inside Cit	y Limits
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Ball	Physician /Medical Examiner		21. Signature of Fupera	Zil	hau	H	_			1160	5 Re:	ister	stowr	Chapel,	Owi	A. ngs M	ills	Md -	21117
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Division of Vital Records, P.O. Box 68	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 □ Yes 2 □ No 9 ☑ Unknown		1	f yes, out 1□Live b 4□Pregn 9□Unkno	oirth 2 ( nant at tim	Fetal	death 3[	Ectopic pr Other (sp						23d. Date Mont			'ear
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			30. Name and address of			eted caus	se of deat	th (Item :	23a) (Type,	Print)		M.E.	et F	Baltimo		Marv			L
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<b>Physici</b>	100	<ol> <li>Decedent's Name (First, Middle, La</li> </ol>	ast)				2. Date of De		Yeer	3. Time of	Death
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Examin		4a. Fecility Name (If not institution, gir			4b. City, Town, or		VCE	4c. Count		<b>D</b> D	
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Funeral Director			1 M 2□F	80 Yrs.	Months Days	Hours Min.	SEP.5,	1923	Cour	ntry) No	J
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or 28a	Funeral Director	10e. Street and Number			10f. Zip Code	01070		10g. Citizen of		ntry?	
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Health and Montal Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 [Yes 2 ]  If Yes, Give Year or Dates:	No WWII	3. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Special Special	ck, White,	etc.	ITE
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		20a. Method of Disposition	·	20b. Place of Dis	position (Name of rematory or other place	; .	Date	20c. Location			
int: If		1 X Burial 2 ☐ Cremation 3 ( 1 4 ☐ Donation 5 ☐ Other (Spec			RANS CEMET	1	2004	OWING	GS MI	LLS, M	iD
Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	Rand		22. Name and Addres 8900 REIST	ERSTOWN F	ROAD - I		_		
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DOUGLAS

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			1 - For Amend Item 4b po	State of Marylar er FH,G829,03/26/0	nd / Departme <sup>04dhb</sup> Certifica	ent of Health and late of Death	Mental Hygiei	ne 2004	09487
			1. Decedent's Name (First, Middle, Las	U)			2. Date of Death	Day Year	3. Time of Death
	Physici /Medio		VICKIE 1	) WALL			3 <i>i</i>	7 04	1.10 M
	Examin		4a. Facility Name (If not institution, give			ty, Town, or Location of Deat	1	4c. County of Death	10
			Calonive	1 701	SING	Baltimore Cit		0.8:45	lone (State or Service
	Funeral		5. Social Security Number 6. S	7. Age (In yrs.	Yrs. Month			ar) Coul	place (State or Foreign
	Director		Usual Residence of Decedent	1 00	<u> </u>		111-00-14		1,100
	ith the Maryland or 28a-f show	ctor	10a, State 10b. County	A 10c. Gi	Bal T	more		1	0d. Inside City Limits 1 Yes 2 □ No
	th with the 23a or 28	Funeral Director	3703 Fledh	nont Av	e 101.	Z1216	10g.	Citizen of What Coul	. V-)
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be profilled at	þ	11. Marrial Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	I.S. 13. Was De If Yes, s	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puerl 221 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
1215-0036	- 79	Completed	15. Decedent's Ec (Specify only highest gra Elementary(Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO	work done during most of wo	rking 16b	Kind of Business/In	dustry
d 21	Hygie Hygie ent.	ပိ	17. Father's Name (First, Middle, Last)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	00.	18 Mother's Nar	(First, Middle, Maid	len Şumame)	OF.
an	ould be filed with Mental Hygiene. arked other than atic event, the	To Be	Calvin	Butter		Ber	nadett	DUV	ALL.
Maryland	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than may injury or other fraumatic event, the Monce.	F	19a Informant's Name Relationship (	Siste	19b. Mailing Address	ess (Street and Number or Ru	AVQ, T	y or Town, State, Zip	(Code)
<u>ة</u>	f Health ftem 27 other tr		20a. Method of Disposition		Place of Disposition (I	Vame of	Date 20c	Location - City or To	own, State
Ë	Pages nert of l int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	01 1	matiny ()3.	-19-04 N	JARyIA	00
Baltimore	permit. Pag Department Important: I any injury o		21. Signature of Fundial Service Licen	flow oll	22. Name	and Address of Facility H	Well Fu	nevel 1.	tome
	<b>8</b> 2		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the deal	th. Do not enter the n	node of dying, such as cardia	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a End 80	tape A	-103			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consec	quende of):	2 \ _			
	Examine	<u></u>	Sequentially list conditions,	b. Due to (or as a consec	CUPYLUY	15			
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 101 20 2 0011000	4201100 017.				
	ate be executed thysician and the burial-transit	Exai	that initiated events resulting in death) Last	Due to (or as a consec	quence of):				
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9	tificat ig phy as th	led							
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn: 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 Ectopic	c pregnancy (specify)		23d. Date of delive Month	ery Day Year
٦.	that I	y Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
Records,	quires n sign	ed by					1 ☐ Yes	2 □ No 3 □ Prob	ably 4. Unknown
000	s been s	Completed					24a. Was an	24b. Were auto	psy findings available mpletion of cause of
Re	The law ate has bage 2	mo					autopsy performed 1 ☐ Yes 2 ☑	? death?	2∕⊠ No
Vital		BeC	25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)		
<u></u>	Physician: this certific ral director,	To	1 ☐ Yes 2 ☒ No		ER/Outpatient 3		lome 5 Residence	6 □Other (Specif	v)
n of	ding Ph. h. After thi funeral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	
sio	Attending r death.	catl	2 Accident investigation 3 Suicide 6 Could not be		M	1 Yes 2 No	28f. Location (Street	and Munhagen Dura	/ Dougla Museline
Division	P afte	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special			City or Town, St	ate)	
	Hospitel 24 hours a Funeral stely filled	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurration and/or investigat	ed at the time, date and place ion, in my opinion, death occu	e, and due to the cause urred at the time, date a	o(s) and manner as si and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	(1 )		29c. License number		Date signed (Month,	
	->-0	Ĭ	I rule st	touxing pi	145 con	D536	42 M	arch 1	\$ 200 ×
-	14		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print) La Parle	D536	3 Bults	mse 21	239
	Sta Regist		31. Date filed (Month, Day, Year)	22. Registrar's Signa		} .~			

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Deeth Decedent's Name (First, Middle, Last) Year **Physician** March 25,2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Hrs. 8. Date of Birth (Month, Day, Year) Kehab ros and 9. Birthplace (State or Fdreign 6. Sex 7. Age (In yrs. last-Months Days Hours 1□ M 21XF 22 Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 □ No Funeral Director owar imbio Vlaryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 XNo ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) (Hus Isand) 21045 62 olumbia 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □Removal from State 130/04 4 Donation 5 Dother (Specify) 32 Names 505 21. Signature of Funeral Service/Dourse oseph F Home S 2222 W. North Avo. 23a. Part i Enter the dishase, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on eech line. Salto Md. 212 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician/Medical Examiner Alzheimers Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA IV Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

ettending physician end of for use es the buriel-trensit Division of Vital Records, P.O. Box 68760, been signed by the should be deteched hes Director: After this certificate d in by the funerel director, peg within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu

**Physician** /Medical

Examiner

**Funeral** 

Director

Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland nent of Health end Mental hygiene.

Int: If Item 27 is marked other than "natural", or Hems 23s or 28s-f show any or other traumatic event, the Medical Examinal must be notified at

altimore, Maryland 21215-0020

Certification: To

edical

27. Menner of Death

1 ☑Natural 2 ☐ Accident 5 Pending investigation 6 Could not be determined 3 Suicide

4 ☐ Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

25348 MD rough 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcia (00 0 mar stown Potomac 706

31. Date filed (Month, Day, Year) State Registrar 2004 32. Registrar's Signature

M			_ State	State of Maryla	nd / Depa	artment of H	lealth and M			+ 09489
	Physicia	an	Registrar  1. Decedent's Name (First, Middle, Last)		Oei	incate or i	Jean	2. Date of Dea	th Day 2004	3. Time of Death
A STATE OF	/Medic Examin	al -	Alfred Foster 4a. Facility Name (If not institution, give str	reet and number)			Location of Death	MARCH 2	4c. County of De	4.05
,	Funeral Director		465-66-3593 **		R s. last birthday) 64 Yrs.	BALTIMO If Under 1 Year Months Days	ORE CITY  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day Aug. 18	. 1939 Re	Birthplace (State or Foreign Country) Public of Panama
	Maryland a-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  Florida Escambia		City, Town or Lo	cation acola				10d. Inside City Limits 1 ☐ Yes 2X No
	h with the 23a or 28 at be no	ai Director	10e. Street and Number 13450 Serenity Cir	cle		10f. Zip Code 32506	j		10g. Citizen of Whal United S	•
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 le markad other than "naturel", or Itema 23a or 28a-f ehow other traumatic event, the Medical Evanther multiplial at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1. Eyes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
15-0	n 72 ho "natur	Completed	15. Decedent's Educa (Specify only highest grade	completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work f)	ing	16b. Kind of Busine	ss/Industry
212	i filed withi I Hygiene. other than	Comp	Elementary/Secondary (0·12)	College (1-4or 5+)	Di	spatcher	40 Markada Mara	- /Fi A B B S	Civil S	ervice
land	ould be fill Mental Hearkad oth	To Be	17. Father's Name (First, Middle, Last) Elijah Burke Foster			100 pt 10	Rosaly F		Maiden Sumame) Sommers	
Mary	and 2 should saith and Men n 27 le marka ser traumatic		19a. Informant's Name/Relationship (Type J.W. Magness, Jr	e, Print) Brother In-Law	1	ng Address (Street			r, City or Town, State	
Baltimore, Maryland 21215-0036	permit. Peges 1 and Depertment of Health Important; If Item 27 any injury or other tr		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b	. Place of Dispo	sition (Name of matory or other place		Date	20c. Location - City Laurel, M	or Town, Slate
Balti	permit. Depertm Importa any inju		21 Signayuri of Funeral Service Liouvu et 23a Part 1. Enter the disease, or complic shock, or hear failure. List only one	Charles no	/42 Pr 21	2. Name and Addre adley—Ash 34 Willow	ss of Facility nton-Matth 7 Spring I	news Fun Road Du		ryland 21222 Approximate
	Physician /Medical Examiner		shock, or hear failure. List only one immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	bral	hemorrh	age			Interval Between Onset and Death
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dua to (or as a cons						
68760,	phys the	cai	d.	Due to (or as a cons	equance or).					
.O. Box	death cer e attendir d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant an the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	lc. If yes, outcome of pred 1 Live birth 2 Fi 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of Month	delivery Day Year
<u>α</u>	luires that I n signed by Ild be deta	by	Part II. Other significant conditions cont Hypertensive		_					e to the cause of death?  Probably 4 XUnknown
Division of Vital Records,	siclan: The law requires that the certificate has been signed by the irector, page 2 should be detache	Completed	1					24a. Was autop perfor 1 00 Yes	sy prior rmed? death	autopsy findings available to completion of cause of ? 'es 2 \( \square\) No
Vita	ysiclan: is certific director.	o Be	25. Was case referred to medical examiner?  TXX es 2 \( \sum \) No	ospital: 1 Thpatient 2	□ FR/Outnatie	nt 3 DOA Oth	26. Place of Deat		ne) dence 6 Other (S	inecifu)
ion of		$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year,	28b. Time o	f 28c. Injur Wor	y at		now injury occurred	posity
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe		reet, factory, office		28f. Location (S City or Ton	Street and Number or vn, State)	Rural Route Number,
	Hospit	Medical (		ician: To the best of my ler: On the basis of exam and manner stated.						
	To the within To the comp	Me	29b. Signature and title of certifier	mis		29c. Licens			29d. Date signed (M	
,	511		30. Name and address of person who con	mpleted cause of death (I	tem 23a) (Type	Print)	M E	Ral+imo	MARCH 23, re, Maryla	
	C)	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnaturge	/	CIAI CEST,	ъат стио	re, mary	MAI CIZUI

Registrar

MAR 2 9 2004

32. Registrar's Signature

Sporks

State of Maryland / Department of Health and Mental Hygiene 2004 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ENNEIH -OSLER 2004 /Medical Marc 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMIRE 66 AIR DAKS AUR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral**  Birthplace (State or Foreign Country) 10 M 2 □ F 217-24-0740 Director JAN 21 Usuat Residence of Decedent 10a. State 10b. County Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinar mast be purified at 10c. City, Town or Location 10d. Inside City Limits NIA 1 Yes 2 No Directo MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 6611 OAKS AUP Funeral 21214 12. Was Decedent Ever in U.S. Armed Forces?

1 Pres 2 No 1 Fres, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: þ 3 Widowed 4 Divorced white NAVY 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12+4 NA CORP ) UPERUISOR thone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) TRABERI HORMAN FOSTER Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BAHO. NO 6611 ARMELA -osLer FAIR DAKS Ave 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 129/04 BAYVIEW CremaTory permit, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility -STELLA FUNERAL HOME CHID. HARTIEY Miller To BA Ho.M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ooset and Death Immediate Cause (Final disease or condition resulting in death) UNG **Physician** Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 See Yes 2 No 3 Probably 4 Unknown ARTCKY 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2.20No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Waturai 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause s) and manner as walled Medical 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ko sens D23319 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 140 OSIER DR Tauson ROSENBL 7600 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 9 2004 Registrar

		-	1 - For State Registrar	State of Marylar		nt of Health and te of Death		iene <sub>eg. No.</sub> 200	4 09491
	Physici	_	Decedent's Name (First, Middle, La.	(1)			2. Date of Deat Month	h Day Year	3. Time of Death
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	Examin	C1			IAIr	Bel Air	.,	Harfo	ord
7	Funeral Director		5. Social Security Number 6. S 212 - 30 - 5388			ler 1 Year If Under 24 Hrs s Days Hours Min		Year) 9. Bin Co	thplace (State or Foreign buntry) St Vi Rgilla
	Maryland f show	tor	Usuel Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Location	)	3.8.3.4.		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28a	I Director	10e. Street and Number	Rd	104. 2	210.50	1	Og. Citizen of What Co	ountry?
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21215-0036	c " m	Completed	15. Decedent's E (Specify only highest gra- Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of s life. DO NOT	work done during most of wo	prking	16b. Kind of Business. MONGOMUA	Andustry BY WARD
Maryland 2	should be filed within and Mental Hygiene. I marked other than umatic event. Lie M	To Be C	17. Father's Name (First, Middle, Last,	Holl		TERSS	me (First, Middle, I	ES.	
Man	d2.0		19a. Informant's ame/Relationship	Type, de daug.	19b. Mailing Addre	ess (Street and Number or R	oral Route Number	, City or Town, State,	Zip Code) 1/050
Baltimore,	Peges 1 and nent of Health ent: If Item 27 iry or other to		20a. Method of Disposition  1 Burial 2 Cremation 3 C  4 Donation 5 Other (Specia	Removal from State	Place of Disposition (A cemetery, crematory of	lame of rother place) Muke	Date 27	20c. Location - City or	Town, State
Baltir	permit. Peges Department of Important: If it eny injury or o		21. Signature of Funeral Service Lice	100	22. Narie	and Address of Facility E	vans Fu	nelal Cra	sel 50
	Physician		23a, Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	th. Do not enter the m		c or respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conse	<u> </u>				
	ped sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consu	uence of				
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.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3 ⊟Ectopid			23d. Date of de Month	livery Day Year
<u>α</u>	50 50	þ	Part II. Other significant conditions	contributing to death but not re	sulting in the underlyin	g cause given in Part I.	23e. Did tol	bacco use contribute to	o the cause of death?
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	Hospital 24 hours a Funeral I tely filled	edical Ce		hysician: To the best of my kn miner: On the basis of examin and manner stated.					
	within 2 To the comple	Med	29b. Signature and title of certifier	and manner states.		29c. License number	2	9d. Date signed (Mon	th, Day, Year)
	/		> s. Pagu	ray. no		D 5342	0 1	nearch 2	41m 20004
	h		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	ed Ped #100	6 Belo	an no	2014
	St Regist	ate trar	31. Date filed (Month, Da	9 2004. Register Sign		mode			

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		land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits	
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		To the within To the Complete	Me	29b. Signature and title of certifier	· A. A	11	10	29c. Licen	se number			29d. Date signe	ed (Month,	Day, Year)	
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		0		30. Name and address of person wh	o completed cause of	death (Item	23а) (Туре.	Print)	1)	c. At	- 10 - 11	20 1	10/	2122	
		2		JHaller	000 N	M	10) ff	31.	15	an	Me	W /	11/	us-t	
		Sta Registr	-	31. Date filed (Month, Day, Year)	32. Regist	ar's Signa	Loure Lou	ach							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** me /Medical 200 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kville a 41 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
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	Emeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year   If Under 24 Hrs.   8	. Date of Birth	9 Birthr	place (State or Foreign
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Maryland	2 sho and Is mu		19a. Informant's Name/Relationship (Type, Print) 19b	. Mailing Address (Street and Number or Rural F	Route Number, City	or Town, State, Zip	Code)
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altimore,	of He fitan r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of cemeter	Disposition (Name of y, crematory or other place)	9 20c.	Location - City or To	own, State
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a	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility			10, 10
m	89 = 8 9		Frette K. Tines	March F/H West 4300 Wabash Ave,	Baltimo	ore Md	21215
	*		23a. Part 1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or re	espiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause /Final	adias passis	400		Onset and Death
	/Medical		disease or condition resulting in death)  a.   Due to (or as a consequence of the content of the	irdiac Reject	107		4 days
8	Examiner		Cardia	o transitiont	-	3	3. 5 years
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):			J
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events				
ó	an ar		resulting in death) Last Due to (or as a consequence of	of):			
8760,	cate be executed physician and the burial-transit	dicai	d				
9	ng pt	Med	IF FEMALE:				
ŏ	eath certifi attending     for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	3 □Ectopic pregnancy		23d. Date of delive	
m m	dea death	Sici	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
о. О	that the de led by the a detached t	h.	9 Unknown				
	36 PB	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
g	w require been signature	ted	Kenal failure		1 Tes	2 No 3 ☐ Prob	ably 4 □Unknown
Records,	law r as be 2 sh	Completed	met hemoglobinemia		24a. Was an autopsy	24b. Were auto	psy findings available inpletion of cause of
	The la cate has page 2	mo.	pulmohary edema		performed? 1⊠ Yes 2□N	death?	2 No
Vitai	ician: Th certificate rector, pag	Bec	25. Was case referred to medical	26. Place of Death (C		.0 .03	<u> </u>
	d is	ToE	examiner? 1   Yes 2   No   Hospital:   Image: Image	tpatient 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify	()
וסר	g Ph ter th neral	ü	27. Manner of Math 28a. Date of Injury 28b. T	7	I. Describe how inj		
Division	after death. after death. I Director: After to d in by the funere	atic	Natural 5 Pending (Month, Day Year) Ir 2 Accident investigation	M 1 Yes 2 No			1
N IS	er de er de recto	iệi l	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office 28f.	Location (Street a	and Number or Rura	l Route Number,
ō	s afte	Certification:	Sundary, etc. (Specify)		City or Town, Sta	(0)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo		29a. Certifier (Check only    Medical Examiner: On the basis of examination and	, death occurred at the time, date and place, and	due to the cause(	s) and manner as st	ated.
	he H in 24 he F plate	edical	(Check only 2 Medical Examiner: On the basis of examination and manner stated.	wor investigation, in my opinion, death occurred	at the time, date ar	nd place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number		ate signed (Month, I	
			pennyer y dema	MU KES-000	Mai	ch Do	2004
	2		30. Name and address of person who completed cause of death (Item 23a) (			0	0.7
	3	ζ,	Jenniki G. Durkan GOON WOIS	fe St. Baltimo	e, MI	0 212	257
	Sta	207	31. Date filed (Month, Day, Year)  32. Registrar's Signature				
1	Registr	ar	MAR 2 9 2004 Seres &	Some V			

			1 - State Registrar	ite of Maryland	Depa <i>Cer</i>	rtment tificate	of He	ealth ar <i>eath</i>	nd Me	ental Hyg	iene 21	004	0949
	Physici		Decedent's Name (First, Middle, Last)     William Wall;	ace He	edwor	th				2. Date of Deat Month March	h Day	Year 2004	3. Time of Death
	/Medic Examir		4a. Fecility Name (If not institution, give street anne Arundel Medica	- 1111			own, or lapol	ocation of I			4c. Count	y of Death ne Aru	
	Funeral Director		5. Social Security Number  310-24-1178  Usuel Residence of Decedent	7. Age (In yrs. last 77	birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day, May 5,	<sup>Year)</sup> 1926	9. Birthpl Coun Ind	ace (State or Foreign try) iana
	he Maryland 88-f show offlied at	Director	10a. State 10b. County  MD Anne Arunde	10c. City, To	own or Loo nnapo	lis							0d. Inside City Limits 1 ☐ Yes ※XXNo
	3a or 2		10e. Street and Number 570 Bellerive Drive	#132		10f. Zip (	<sup>2140</sup>	1		11	ng. Citizen of USA		try?
2020	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23s or 28s-f show aumatic event, the Medical Examiner must be incitified at	d by Funeral	11. Marital Status 12. Wa Aq 1 Never Married 2 Married 1.2	as Decedent Ever in U.S. ped Forces? §Yes 2 □ No 'es, Give ar or Dates: WWII			ent of Hisp fy Cuban,	panic Origir Mexican, f	n? (Spec Puerto Ri	ify Yes or No- ican, etc.)	14. Ra	ce - America ck, White, 6	
Maryiand 21215-0036	within 72 h ene. thsn "natu ha Medical	Completed	15. Decedent's Education (Specify only highest grade comp.  Elementary/Secondary (0-12) Co	llege (1-4or 5+)	(Give I life. D	O NOT use	done du retired)	ring most o	f working	7	16b. Kind of E		·
א סר	e filed Il Hygi other	Be Co	17. Father's Name (First, Middle, Last)	4 I	TOFTE	age B			Name (	First, Middle, N		tment	S
ylai	should b and Ments marked	To	Claude A. Hedworth  19a. Informant's Name/Relationship (Type, Pri			*		Lura					
	and 2 st salth and n 27 is n		Jacklyn W. Hardest	.,						Route Number. Edgewate		•	-
baitimore,	- I = =	100	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	20b. Place	of Dispos	ition (Name atory or oth	of of		Dat		20c. Location		
Ě	it. Pages intment of I intent: If its njury or o	9	* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Metro			4		29/2	004 B	altimo	re, M	D
g	permit. Departr Importa sny inji		21. Signature of Pulletan Service Licensee	an Wilt	- 1	Name and Harde	sty :	Funera	al H	ome, P. Annapo	A.	D 21/	0.1
	death certificate be executed  Water and mand mand and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events c.	oue to (or as a consequence	e of):	-	sea						Interval Between Onset and Death
.C. DOX 0	death certific e attending p od for use as	by Physician/Med	in the past 12 months?	es, outcome of pregnancy Live birth 2 Tetal dea Pregnant at time of death Unknown		Ectopic pred Other (spec						te of deliver onth [	y Day Year
.L (cp.	ires tha signed d be de		Part II. Other significant conditions contributing	g to death but not resulting	in the und	derlying cau	ise given	in Part I.			acco use cont	ribute to the	cause of death?
	The law ate has b page 2 s	Completed							_	24a. Was an autopsy perform 1 Yes 2	ed?	prior to com death?	sy findings available pletion of cause of
VIId	Physicien: Th this certificate ral director, paç	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hospital	1 ☐ Inpatient 2 ★ R/C		-7.00	Other		-	Check only one		-	
	ding After fune	ertification; T			Time of Injury	3 DOA 280	: Injury at Work?			5 Resider			
	itel or Attendins after deatling by the led birector:	Certific	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, o	office		28f	Location (Stre City or Town,	et and Numb State)	er or Rural	Route Number,
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical	13d Cantilor 10 Centrying Physician. (Check only one) 2 Medical Examiner: On any	To the bast of my knowledge the basis of examination a manner stated.	ge, death o ind/or inve	stigation, in	the time, my opin	date and pi ion, death d	ace, and occurred	i due to the cau at the time, dat	ise(s) and ma e and place, a	inner as stat and due to t	ted. he cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	4 3		29c. l	icense n	umber	·	290	d. Date signed	1 (Month, D	ay, Year)
			30. Name and address of terson who complete	d cause of death-filtern 23a	(Type, P	rint)	35	758	.1	3	125/	04	,
	Sta Registra		Da Clet Sing ( 31. Date filed Month, Day, Year)	d cause of death-filem 23a 2. Registrar's Signature	141-	5 //1 8 p	naf	My	Kou	4 # 1	06 04	levto	W MD 211L

State of Maryland / Department of Health and Mental Hygiene 2004- State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MARCH 27,2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 🕱 F Director with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Show rel', or items 23e or 28a-f sh Examiner must be notified 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2408 2108 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ØNo 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 is marked other then "naturel", or Ite ury or other traumatic event, the Modical Examina. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify If Yes, Give Year or Dates: Specity: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1085 Paymond 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State Importent: If it any injury or o once. 1 Burial 2 □ Cremation 3 Removal from State March 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sen ce Licens 22. Name and Address of Facility ans 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ATRIAL RUPTURE HOUR /Medical resulting in death) Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE 15 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last CAROTID STENOSIS LEFT YEAR Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð should be 2 X No 3 Probably 4 Unknown 1 Tyes Completed has been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 this certificate 1 Yes To the Hospital or Attending Physicien: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? 2 No 1 X Inpatient Other: Certification: To 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the To the Funeral Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 28 2004 D 38570 of person who completed cause of death (Item 23a) (Type, Print) JEFFREY EDWARD 7601 OSLER DRIVE TOWSON, MARYLAND 21204 M. D. Registrar's Signature 31. Date filed (Month, Day, Year) 32. State MAR 2 9 2004 Registrar

				1- State of Maryland / Department of Health and Certificate of Death		giene 2004	09497
4		Physic /Medi		1. Decedent's Name (First, Middle, Last)  JAMES IRA HOPKINS	2. Date of Deat Month		3. Time of Death
		Examir Funeral Director		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Dead  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  1 Months Days Hours Mir  4b. City, Town, or Location of Dead  BALTIMO  7. Age (In yrs. last birthday)  Yrs.  Wonths Days Hours Mir  Usuel Residence of Decedent	S. 8. Date of Birth	4c. County of Death  Year)  9. Birth Co  22	hplace (State or Foreign unity)
		72 hours after death with the Maryland natural; or items 23s or 28e-f show dical Examinat must be notified at	ector	10a. State 10b. County 10c. City, Town or Location  MD Queen Anne's Stevensville			10d. Inside City Limits 1 □ Yes 2 No
		sath with the 23s or 2	Funeral Director	100. Street and Number  101. Zip Code  21666		0g. Citizen of What Co	7
	920	burs after de rai', or itam Exaπimer r	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, specify Cuban, Mexican, Pue Year or Dates:  13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue Year or Dates:	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	nican Indian, o, etc. hite.
	1215-0	s 1 and 2 should be filed within 72 hours after death with the Maryiar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, if a Mudical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1/4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired)  FORE MEAN	orking	16b. Kind of Business/f	
	land 2	12 should be filed within in and Mental Hygiene. I is marked other than "raumatic event, tra Med	To Be Co	7. 10.07.17.10	me (First, Middle, M	BETHLEP Meiden Sumame) DS_FRIA	7 P
us	, Mary	1 and 2 shou Health and M am 27 is mar other traumat		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Relationship)  111 Wicomico Relationship		100	ip Code)
810	altimore, Maryland 21215-0036	Page nent c ent: if ury or		20a. Method of Disposition  1 A Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cometery, crematory or other place)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Ry	8-2004. 6	POCENS BOYCE	nc.
7	Ba	Depermit. Depertr imports eny inji		23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only doe cause on each line.	ALTIMORE  APEL - 880  Ic or respiratory arre	00 HARFOR	Approximate
4/6		Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Liver Failure  Due to (or as a consequence of):			niterval Between Onset and Death Months-y
15 3iz	68760,	ate be executed hysicien and he burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Sclerosing Chulangifts  Due to (or as a consequence of):  Due to (or as a consequence of):  d.			
OPKI	O. Box (		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   5   Other (specify)   1   1   1   1   1   1   1   1   1		23d. Date of deliv	ery Day Year
R F	Records, P.	requires that the death	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Crown's Discase		acco use contribute to t	,
H	Vital Rec	2 2	e Completed	25. Was case referred to medical		ed? prior to co death? No 1 \( \subseteq \text{Yes}	opsy findings available empletion of cause of 20 No
28	of	Phys this aldi	To B	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	ath (Check only one)	nce 6 ZOther (Specif	w Hospice
Sam	Division	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerei Director: After this certificate h completely filled in by the funeral director, page	Certification:	27. Manner of Death    Matural   5   Pending investigation     Suicide   6   Could not be determined   4   Homicide   Homicide   Homicide   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury at Work?     M   1   Yes   2   No     28a. Date of Injury   28b. Time of Injury at Work?     1   Yes   2   No     28a. Place of Injury - At home, farm, street, factory, office     28b. Place of Injury - At home, farm, street, factory, office	28d. Describe how 28f. Location (Stre	eet and Number or Rura	al Route Number,
1 /	Ō	To the Hospitel or within 24 hours after to the Funerel Di completely filled in	edical Ceri	29a. Certifier (Check only)  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	City or Town,		tated.
•		To the P within 24 To the F complete	Medi	29b. Signature and title of certifier  D 2 + 1.7 o		d. Date signed (Month,	
		10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  E. TSO MD Richard Hessia R. & R. & D. Eults at St. Ra	1 finare	MD 200	2204
		Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature		1-1/ 212	<i>&amp;</i>
	DHI	MH 17 Rev 1/20	01	ORIGINAL			

		•	1 - For State Registrar	State of Ma	ryland / De	partment of H ertificate of L	ealth and N Death		ene 2004	09498
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Vincent L.  4a. Fecility Name (If not institution, give	Hug street and number)		4h City Town or	Location of Death	March	25, 2004 4c. County of Death	4:45 p.м
	Examin	er	1801 Wadsworth V			Balti			n/a	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director		213-16-0884	<b>X</b> )M 2□F	89 Yrs.			Aug. 19.	1914 Ne	ew York
	land w m		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	a-f sh	ctor	Maryland n/a	ì	Balti	more				1 X Yes 2 No
	or 28	Director	10e. Street and Number	lav		10f. Zip Code	21239	10	g. Citizen of What Cou	
	eath w	erai	1801 Wadsworth V	12. Was Decedent B	ver in U.S. 1	3. Was Decedent of Hi	ispanic Origin? (Sc	pecify Yes or No-	United S	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic syant, fra Medical Exat	by Funerai	1 ☐ Never Married 2 ☐ Married  3(X) Widowed 4 ☐ Divorced	Armed Forces?  1 XYes 2 N If Yes, Give Year or Dates:	4000	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	Rican, etc.)	Black, White	, etc.
2-0	72 ho	Completed by	15. Decedent's Ed (Specify only highest gra-		(Gi	cedent's Usual Occupa ve kind of work done of	furing most of work	king 1	6b. Kind of Business/l	ndustry
121	e filed within al Hygiene. I other then " vent, the Me	mp	Elementary/Secondary (0-12)	College (1-4or 5 2 VYS	+)	o. DO NOT use retired. Electronic	,	ian	Electr	onics
<u>d</u>	Hygi other	Be C	17. Father's Name (First, Middle, Last)				_	ne (First, Middle, M		
/lar	should be ind Mental marked o	To B	Roy Hug				Anna	Finne	jan 	
Man	nd 2 sho lith and 27 is m		19a. Informant's Name/Relationship (7) Mrs. Cindy A. Scho			alling Address (Street a			City or Town, State, Z , Maryland	ip Code) 21047
ore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tru		20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗔	Removal from State	20b. Place of Dis	sposition (Name of rematory or other place alley Mem. Go		Date 2 /29/2004	oc. Location - City or Timonium	
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Healt Important: If item 2 sny injury or other ance.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		1	22. Name and Addres	ss of Facility	53	05 Harford	Road
	40 = * a		23a. Part1. Enter the disease, or compshock, or heart failure. List only	thations that caused	the death. Do not a	Leonard .	J. RUCK,	or respiratory arres	ltimore, M	D 21214 Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a ATCU	a consequence of:	ocardiz	linfa	nctin	1	Interval Between Onset and Death
d	Examiner	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
_6	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
8760,	cate be ex ohysician the buria	dicai E	•	d						
9	leath certifica attending ph d for use as ti	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of delin	/erv
.O. Box	the c y the	Physician/Me	in the past 12 months?  1  Yes 2  No 9  Unknown	1□Live birth 4□Pregnant at 9□Unknown		3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
S, P	The law requires that tte has been signed b page 2 should be deta	by PI	Part II. Other significant conditions of	ontributing to death be	ut not resulting in the	e underlying cause give	en in Part I.		acco use contribute to	
ord	w require been si should		Lancer	· · · · · · · · · · · · · · · · · · ·					s 2 No 3 Pro	bably 4 Onknown
3ec	e law has b	Completed						24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
Vital Records,		e Cor	25. Was case referred to medical				ge place of D	1 Yes 2	PNo 1 □ Yes	2 No
Ξ	Physician: this certific ral director.	0 8	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpai	tient 3 DOA Othe	ar.	th (Check only one	nce 6 Other (Spec	ıfv)
J of	ig Phy ter this	T: L	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inju-	ry 28b. Time	of 28c. Injury	at	28d. Describe how		.,,,
Sior	ttending death. ctor: After	catio	2 Accident investigation	1	,		Yes 2 □No			
Division	al or ttending F safter death. al Director: After ed in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
~	To the Hospital or within 24 hours after To the Funaral Director completely filled in the funaral birector of the funaral birector filled in the funaral bi	Medical (	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam one)	ysician: To the best niner: On the basis of and manner sta	examination and/or	eath occurred at the time r investigation, in my op	ne, date and place pinion, death occur	, and due to the car rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and tale of certifier	m	~	D 2	5733	29	d. Date signed (Month	Pay, Year)
			DUNCAN	completed cause of d	eath (Item 23a) (Typ	560 i	Loch	Rave	n Bival	Baltm
	St Regist	ate	31. Date filed (Month, Day, Year)		ar's Signature					21239
DI	HMH 17 Rev 1/2	- 7	2007	- FRETER	-63	(E)				

			For State Registrar		State of	Marylar		artment of H		F	Reg. No. 20	04	09499
2221	Physicia	-	Decedent's Name (First, Market Thelma	Middle, Last,		Viola		Но	11v	2. Date of Dea Month MARCH	Day 2004	Year	3. Time of Death  11:40 am <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not insti	tution, give					Location of Death		4c. County		
			GREATER BALT	IMORE	MEDICA	L CENT	ER	TOWSON			BALTIM		
	Funeral Director		5. Social Security Number 217-23-4447	6. Se	х Эм <b>Х</b> (Х) г	. Age (In yrs. 9 <b>7</b>	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 12 20	y, Year)	9. Birthp Cour	place (State or Foreign htry)
	D .		Usual Residence of Decede	nt		10c Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	shov	ō	_				ltimo						1X Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show	Director	MD N	IA		Da	ICIMO	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	h with		816 North B	remo	nt Ave			2.	1217		U.S.	Α.	
	ems ?	Funerai	11. Marital Status		12. Was Deced	lent Ever in L	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Raci Blac	e - Americ k, White,	ean Indian, etc.
<b>36</b>	rs afte	by Fi	1 ☐ Never Married 2 ☐ 3 🎖 Widowed 4 ☐ Dive	1	1 ☐ Yes 2 If Yes, Give Year or Da	X No tes:		1 ☐ Yes <b>2</b> XNo	Specify:		Specify	': В.	lack
-0036	2 hou	ted	**	edent's Edu	ucation		16a. Dece	dent's Usual Occup	ation	(ina	16b. Kind of Bu		
215	within 72 ene. then "ne!	Completed	Elementary/Secondary (0		College (1-	4or 5+)		kind of work done of DO NOT use retired	4)		Des		_
22	e filed within all Hygiene. I other than "	Cor	7th grade 17. Father's Name (First, Mi	ddle Last)	na		Do	mestic	18. Mother's Nam	e (First, Middle,		lvat	e
and	Tr. Father's Name (First, Middle, Last)  Property  Charles H. Hall  Mary E. Wors												
ary	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Num												_
_ ≥	1 and 2 Health (18m 27 is	Î g	Gladys Ster	vart-	Daught			Cuthbe	The second second	Baltır	nore Mo		1215
ore	Pages 1 nent of H ant: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema	ıtion 3 ∏l	Removal from S	erate		osition (Name of matory or other place	1			•	
王皇	permit. Pages Department of I Important: If Its any injury or o		4 ☐ Qonation 5 ☐ Oth 21. Sign ture of Funeral Se			Mt		urn Cem		/29/04	ватсти	nore	, Ma
Balti	permit. Departn Imports any inju	1	DY US	K	sok.	ke.	4	300 Wab	ash Ave			1d	21215
1			23a. Part1. Enter the disea shock or heart faitule	se, or comp	lications that ca	used the dea	th. Do not en	ter the mode of dying	ng, such as cardiac	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_	a Acu	Te C	ereb	rovasc	ular	prom.	hose	2	1 day
	/Medical Examiner	h	resulting in death)		Due to (c	or as a conse	quence of):	10-					/
M	useli.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	J	b	or as a conse	quence of):						
	ate be executed nysician and he burial-transit	Examiner	that initiated events	1	c								
760,	e be executed /sician and e burial-transit		resulting in death) Last		Due to (	or as a conse	quence of):						
387	leath certificate b attending physicate of for use as the b	dicai		•	d								
Вох 68	n certif	n/Me	IF FEMALE: 23b. Was decedent pregna	nt	23c. If yes, outo	come of pregr		∃Ectopic pregnancy	v			te of delive	
Э. В	a death	Physician/Medi	in the past 12 months 1 Yes 2 No	?		ant at time of		Other (specify)	,		Мо	nth	Day Year
P.O.	that the de ed by the detached	Phy	9 ☐ Unknowń Part II. Other significant co	onditions co	ontributing to de	ath but not re	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did t	obacco use cont	ribute to t	he cause of death?
ds,	uires tha signed id be de	d by								1 🗆 '	Yes 2□No	3 Prot	pably 4 Unknown
cor	s been signature	Completed								24a. Was	an 24b.	Were auto	opsy findings available impletion of cause of
Re	Physician: The lav r this certificate has ral director, page 2	mo								perfo	rmed?	death? 1 🗌 Yes	2 No
/ita	cian: ertifica ector. I	Be	25. Was case referred to mexaminer?	nedical	Unanitali		,	0#	26. Place of Dea	th (Check only o	one)		
of \	Physic this c	2	1 Yes 2 No		Hospital: 1 ☐ II		ER/Outpatie	nt 3L DOA			dence 6 Oth		(y)
on	ding Phy th. After this	tion	1 Natural 5 1	Pending nvestigation	(Mont	h, Day Year)	Injury	Wo	rk? ]Yes 2∐No		,.,		
Division of Vital Records,	To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director. page 2 should be detached for use as the	Certification:	3 ☐ Suicide 6 ☐ 6	Could not be determined	289. Place	of Injury - At	home, farm, st	reet, factory, office		28f. Location ( City or To		er or Rura	al Route Number,
Ď	oitel or ars after rel Dia												
	Hosp 24 ho Fune etely (i	Medical	29a. Certifier 1 X Ce (Check only one)	dical Exam	ysician: To the niner: On the ba and manr	asis of examin	nation and/or i	th occurred at the timestigation, in my o	me, date and place opinion, death occu	rred at the time,	date and place,	and due t	o the cause(s)
	To the within To the comple	Σ	29b. Signature and 11s of	certilian	// 1.			29c. Licens		2	29d. Date signe		
			1/170	0	each n	2)			12640				
	2		30. Name of address of p	erson who	completed caus	e of death (Ite	em 23a) (Type 600	Print) 0520	ER A	4. 701	VSON	M	21204
		ate	31. Date filed (Month, Day, MAR 2 9	Year)	32. R	egistrar's Sig	nature	/					
	Regist	rar	minit & J	4004	18 30-100		D ,	Inn. W					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARY T. HOLTHAUS MARCH 2004 /Medical 6:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HERITAGE NURSING CENTER DUNDALK BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Year) 5/1/15 **Funeral** 9. Birthplace (State or Foreign Days Hours 1 ☐ M 2 🖫 F 213-20-7915 Yrs. Director 88 MARYĹAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-1 show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1039 ELTON AVE. or items 23a 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 À 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced 'naturel', WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) : 1 and 2 should be filed wi Health and Mental Hygien tem 27 is marked other th RECEPTIONIST MURSEY COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BRADLEY M. HALLER THERESA NIGL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. JOHN HOLTHAUS 1039 ELTON AVE. BALTIMORE, MD. Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 3/29/04 BALTIMORE, MD. 21. Signature of Funeral Service Lice KÄCZOROWSKI FAFUNERAL HOME P.A. any is AVE. BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ARCINOMA Immediate Cause (Final A Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a contactioned of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregrant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Be Completed by CARDIO VASCULAR -SCLEROTIC 1 ☐ Yes 2 ☐ No 3 Probably ENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' MELLIT 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospitel or Attending Division 1 aturaf 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha I within 2. To the I complet 29b. Signature use of death (Illam 23a) (Type Printly 32. Hegistrar's Signature 31. Date filed (Month, Day, Year) MAR 2 9 2004 Registrar